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OF
SKIN AND VENEREAL DISEASES

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Original Communications

BUCCAL ULCERATIONS OF CONSTITUTIONAL ORIGIN.*

BY EDW. WIGGLESWORTH, M.D., AND E. W. CUSHING, M.D.,
BOSTON.

DURING the past three years a large number of patients with deep ulcerations of the fauces and palate have applied for treatment at the Out-Patient Department of the Boston City Hospital.

As a rule these had been unrecognized, neglected, or badly treated outside by uneducated practitioners or druggists' clerks, who, by abundant and ill-timed cauterization, and by over-doses of mercury, increased the disposition, already existing, of the poorly nourished tissues to break down, and hindered all attempts at repair.

These cases were by no means confined to poor and illiterate members of society, and in many instances the patients were wholly ignorant of the nature of their malady. It may be well to observe that such lesions are often grouped by the general public, following the lead of charlatans, under the head of "catarrh"; that it is chiefly owing to this confounding of diseases that "catarrh" has such a terrible reputation, and furnishes quacks with such power to frighten and plunder their victims, who, suffering perhaps from a slight chronic post-nasal catarrh, are filled

* Read before the Am. Dermatological Asso. Newport, R. I., Aug. 1881.

with fears of frightful ulcerations and wasting consumption. The fact that syphilitic ulcerations sometimes occur in persons above all suspicion of sexual immorality makes it doubly important for the general practitioner to recognize them by their appearance, without asking too many questions; while the brilliant results following rational treatment, even in desperate cases, make even these very satisfactory subjects for treatment.

The appearance of these ulcers is usually quite characteristic, and even when it may not be possible to say certainly that the case is one of syphilis, yet in the matter of treatment the doubt is of little consequence. The only maladies likely to occasion doubt in regard to diagnosis are lupus, and tuberculosis, and occasionally epithelioma. In cases of lupus the local treatment is identical with that adapted to ulcerations due to syphilis. When tuberculosis exists with ulcerations of the fauces, or palate, or both, the pulmonary symptoms are almost always far advanced; and, even when they cannot be detected, the patient is sure to die of tuberculosis, more or less general; and treatment is practically useless. The possibility, however, that the case may be one of either of these diseases should always make the practitioner careful in expressing an opinion, and considerate in his language, for the peace of a whole family is often at stake. Though at the same time neither disease excludes syphilis, and, in the absence of marked pulmonary symptoms, the great comparative rarity of lupus or tuberculosis limited to the throat alone makes it almost always judicious to try the effect of a mild antispecific treatment, combined with cod-liver oil, alterative and tonic remedies, and the local treatment about to be described; for these are equally valuable in cases of lupus or of syphilis, and can do no harm in those of tuberculosis or of epithelioma.

The "diagnosis a juvantibus et nocentibus" thus obtained is more trustworthy in doubtful cases than one founded on the denials of patients, who have many motives for falsehood or concealment, not to speak of honest ignorance due to the deficient powers of observation appertaining to the average patient.

Of course in all cases the evidences of syphilis in other parts of the body, or the history of its manifestations, should be diligently sought for, for these, if found, warrant a positive diagnosis which the appearances in the throat alone would hardly justify.

The difficulty in distinguishing between ulcerations caused by syphilis, lupus, or tuberculosis, from their appearance alone at any one time, arises from the fact that they are all produced in a similar manner, viz., by infiltration of tissues with a mass of small cells, which, not being properly nourished, dies and sloughs out, leaving an ulcer by no means always typical in appearance. There is, however, no difficulty in distinguishing these from simple aphthæ, or from syphilitic excoriations, or from ulcerations caused by broken or jagged teeth. The first two are shallow and occur usually upon the tongue or cheeks; for the last there is also an evident local cause. Epithelioma almost always begins either in the lips, or upon the tongue, or in the larynx, and in the last two situations may sometimes lead to difficulty, as it has already led to errors of diagnosis; but deep ulceration of the soft or hard palate, the fauces, pharynx, or tonsils, is almost always due to syphilis, though in rare cases it may originate from lupus or tuberculosis, even though there are no other signs of either of the latter diseases.

In these cases, with the exception of tuberculosis, a rational treatment is followed by the most gratifying results; the ulcers rapidly heal, the sloughy base becomes covered with bright granulations, and even the worst cases yield good results. A few cases will illustrate this, although the first terminated fatally.

CASE I.—W. T., æt. 19, sent for Dr. Cushing in great haste, the messenger saying that the patient was dying. On arrival he was found to be bleeding from a huge chasm, comprising the pharynx, fauces, and infundibulum of the ethmoid, *i. e.*, nasal fossæ; the hard and soft palates were gone. The hemorrhage was checked by a wad of cotton soaked in a solution of tannin, which was carefully removed the next day; a slight hemorrhage ensued, which ceased on application of cold water by a syringe through the nose. Patient was very weak, and suffered from anasarca of the lower

extremities and from great difficulty in swallowing food. Urine albuminous, no fever. He died exhausted on the fifth day. His father had syphilis; his mother was already infected at the time when he was born, and at this time showed evidences of syphilis in ulcerating gummata of the skin. The patient had "never had any opportunity of contracting the disease himself," and there was in his history the fact of symptoms of syphilis soon after his birth.

CASE 2.—Lizzie T., æt. 33, married eleven years, applied for treatment with the following history.

Soon after marriage she miscarried, and this happened three times subsequently. Had been separated from her husband, a dissolute man, for several years; "never had intercourse with any other man." Had sore throat seven years ago and at intervals afterward. For last three years her throat had troubled her greatly, becoming, in spite of treatment, steadily worse. On examination the whole of her soft palate was seen to be gone, also a triangular piece of the hard palate about 3 cm. (one and one fifth inches) wide at the base, the loss of substance extending forward to within 3 cm. (one and one fifth inches) of the teeth. The whole surface exposed to view was ulcerated, sloughy in some places, in others partly covered with unhealthy granulations, the whole bathed with a foul, yellowish secretion.

The patient was unable to speak intelligibly, owing to the loss of the palate; she swallowed with great difficulty, was much emaciated, and very weak. She was admitted to the hospital for rest, proper food, and general treatment, which consisted of cod-liver oil, ferric iodide, and potassic iodide. Three times weekly she came to the out-patient department for local treatment, which consisted in the topical application of iodine spray and insufflation of iodoform. It was easy to observe the very beneficial action of the spray in cleansing and stimulating the parts; large quantities of foul secretion were washed away, and after about two weeks the ulcerated surfaces began to be covered with healthy granulations, which bled slightly under the influence of the stimulant spray. The patient remained under treatment in the hospital for about four months, when she was discharged stronger, stouter, and well able to take food. She came as an out-patient for local treatment for two months longer, at the end of which time the whole surface was cicatrized. About a year later she reappeared, complaining of contraction of the jaw; and in fact she could only open her mouth a distance of 2 cm. (eight tenths

of an inch), owing to a tough cicatrix over the left masseter muscle. The tongue was adherent to the post-pharyngeal wall to the extent of 1 cm. (four tenths of an inch), also to the left side of the pharynx, the arches of the palate, and the tonsil, leaving a relatively small opening for swallowing and breathing. She experienced no great difficulty, however, and was chiefly concerned about her speech, which was nearly unintelligible, owing to the absence of the palate. A skilful dentist very soon arranged a plate which remedied this entirely, and her health has been good for the last year.

CASE 3.—John D., æt. 23, presented himself at the hospital suffering from a deep ulceration on the point of the tongue, and another in the pharynx. The ulcer upon the tongue was round, $2\frac{1}{2}$ cm. in diameter, 1 cm. (four tenths of an inch) in depth, its base uneven, the secretion yellow and scanty; there was no inflammatory areola, and very little swelling of the tongue. No history of syphilis, but possibility of infection not denied. No symptoms of phthisis pulmonum. Admitted; was given cod-liver oil, tonics, and potassic iodide. The diagnosis was probable tuberculosis, with possible syphilis—as the ulcer on the tongue looked much like a sloughing gumma. The pharyngeal ulcer was long, shallow, painful, yellow at base, the sides not punched out; there was no inflammatory areola. Locally iodoform was used, with some relief to the pain; also iodine spray. The lingual ulcer utterly refused to heal, that in the pharynx spread, and others appeared as minute yellow spots near its borders, these last ulcerating themselves subsequently. Fever came on in about three weeks; the patient went home at the end of five weeks; laryngeal ulcerations soon came on, and dyspnœa and cough appeared, with fever and inability to swallow. There was great dysuria, and the patient perished miserably of general tuberculosis seven weeks from his first appearance at the hospital and about ten weeks from the inception of the ulceration on his tongue. This case is very interesting from the fact that lingual tuberculosis appeared before any pulmonary symptoms could be detected by the most careful observation. Such cases are rare, but well authenticated.

The first of the kind published of which we have knowledge was in a memoir read to the Académie in 1869 by Dr. U. Trélat. This case consisted in a “small nodule, firm rather than hard, occupying the left border of the tongue, a little in front of its centre.

"The nodule was ulcerated at its summit, which was directed toward the inferior surface of the organ, and the ulcer, with abrupt edges, rosy-gray base, nodular and vegetating, was about 1 cm. (four tenths of an inch) broad and somewhat irregular in contour. In front, and quite near, were two little superficial ulcerations, and some days later there appeared several little grayish-yellow spots, the semeiologic value of which was not then appreciated."

There was no symptom of syphilis, no cough, souffle, nor hemorrhage of any sort, although mastication was somewhat impeded, no bad teeth, no swelling of the submaxillary glands, and not much thickening around the ulcer. No positive diagnosis was made. Antisyphilitic treatment was tried for a month, and then the patient went home. Six months afterward he returned. The ulceration was somewhat larger, extending toward the frenum linguæ; it had become painful during mastication; the base was gray; the entire tongue was stiff, seemed a little swollen, and was bathed in a copious saliva which the patient was obliged to wipe away frequently; the little yellow points mentioned above had become somewhat more numerous, and extended beyond the median line toward the right side; the submaxillary glands were unaffected, as before. Dr. Trélat was more undecided than ever, therapeutic measures had made syphilis improbable, the lesion was still less like an epithelioma; various washes of borax, tannin, and tinc. iodine were tried unsuccessfully during a month, at the end of which time the patient again left the hospital on Feb. 20th. There were now some signs of pulmonary tuberculization at left apex. On May 26th he reëntered the hospital for the last time. His condition was much aggravated, the right border of the tongue was occupied by an ulcer similar to that on the left; the inferior surface of the organ was invaded, and on the dorsal surface could be seen little erosions surrounded by a bright-red margin; the tongue was swollen and very painful, mastication impossible, salivation abundant and continual, and there existed insomnia, insufficient nutrition, anxiety and emaciation. The tongue was thoroughly cauterized by the hot iron, under anæsthetics, by advice of M. Broca. The eschars came away in the beginning of June, and the subjacent surface was pale yellow. The ulcers were twice touched subsequently with a caustic solution of carbolic acid. The result was excellent; the tongue was very little swollen, more supple, less painful; the points cauterized were pink

and of healthy appearance ; nourishment much easier. Hopes of a cure were entertained, when, on June 17th, the patient had a chill, and died on the 28th, of acute miliary tuberculosis of the lungs, mesentery, etc. The tissues of the tongue at the level of the cauterized ulcerations were found to be studded with little gray, or opaline, miliary granulations, blending at their peripheries with the surrounding tissues, and penetrating to a depth of about a centimetre (four tenths of an inch). M. Trélat is satisfied that the actual cautery is useful in such cases as a relief from pain and swelling.

Ricord published a similar case where pulmonary symptoms did not appear until about eight months after buccal ulceration of a tuberculous nature was observed. Such cases are rare and may give rise to grave errors of prognosis and treatment unless recognized : when, as is usual, the ulcerations appear in persons evidently phthisical, the diagnosis is easy, although it must always be remembered that syphilis and tubercle do not exclude, but, on the contrary, aggravate, each other. M. Trélat, in his case, very properly drew attention to the minute grayish-yellow spots appearing in the neighborhood of the ulceration and afterward breaking down into minute ulcers, and perhaps thus irregularly enlarging the original ulcer, a process which had been already very carefully described by Türk in connection with tuberculous ulceration of the larynx.

CASE 4.—Mrs. H., æt. 53, married. Had always been healthy and of exemplary character. Three years ago contracted syphilis from her daughter by inoculating her finger at the time of the daughter's confinement. She, in turn, had contracted the disease from her husband, and by his confession, and by the symptoms of mother and infant, there could be no doubt as to the nature of the disease. Three months before applying at the hospital Mrs. H. had what she supposed to be diphtheria, which had left an ulcer in the hard palate in the median line, 3 mm. (one tenth of an inch) in diameter. In order to improve her voice the patient used to make a small piece of thick brown paper adhere to the roof of her mouth. The ulcer was perforating, with yellow, uneven, perpendicular edges. There were, in some places, pale and unhealthy granulations. Much ozæna and great trouble in nose, with swelling, redness, and tenderness over the nasal bones. Potassic iodide and mercuric bichloride were given, and the iodine spray was used vigorously, especially by sending it through the

opening into the palate. The case was rather tedious, the nasal bones exfoliated, and small pieces of them came away; but these were replaced by new bone from the periosteum, so that the nose did not fall in, although it remained somewhat thickened. Several pieces of bone were removed through the opening in the palate, the largest $1\frac{1}{2}$ cm. (three fifths of an inch) long and 1 cm. (four tenths of an inch) wide, triangular and apparently a part of the vomer; another irregular piece, very offensive, was apparently part of the ethmoid. The bones could be felt with a probe to be denuded and partially loose; finally they became so loose that, with great care, they were detached and removed at intervals by forceps through the palatal opening, which then soon healed and the ozæna ceased. The patient apparently recovered her general health perfectly, but harmony was never reëstablished in that family.

CASE 5.—Louisa P., æt. 27. Six weeks ago first noticed sore throat, which was cauterized; soon after there was an ulceration of the genitals; an old ulcer on the leg, where bone had been removed many years before, also reopened. Two weeks ago noticed an eruption on face, which is still visible, and is a papular syphiloderm. Jan. 7th, applied for treatment. Throat shows shallow ulcerations of arches and of posterior wall of pharynx covered with gray secretion, surrounded by shining or partially opalescent tissues.

Potassic iodide and ferric iodide internally, iodine spray locally.

Jan. 26th. General symptoms better, eruption gone, ulcer of leg much better, nearly healed. Ulcers on arches healed, on posterior wall of pharynx much improved.

Feb. 5th. Ulcerations all healed, general health much improved.

CASE 6.—Mrs. J. D., æt. 34, married. Appeared at the hospital suffering from an ulcer perforating the hard palate, and with symptoms of necrosis of the nasal bones. The ulcer was round, 3 mm. (one eighth of an inch) in diameter, situated in the median line, 12 mm. (half an inch) from the junction of the hard and soft palates. A smaller ulcer, 2 mm. (one line) in diameter, perforated the soft palate a little to the right of the median line.

Dead bone could be felt with a probe through the larger opening. The ulcers were regular, their secretions scanty, and there was no inflamed areola. No history nor symptom of syphilis in

the case of the patient, nor in that of her husband. Correspondence with the family physician, whose intimate knowledge of the case covered a period of ten years, failed to supply any history of syphilis. It was ascertained, however, that the mother and an aunt of the patient had died of phthisis; also some remote members of her family. Patient had some cough, had lost greatly in weight, and night sweats had recently appeared. The ulcer had first been noticed about three weeks previously. It was diagnosed as probably lupus, and cod-liver oil with malt and iodide of iron were ordered internally. Locally, iodine spray and iodoform were used three times weekly, being blown in through the ulcers. The nose was kept clean by the daily use of the nasal douche with a warm solution of potassic chlorate and permanganate and sodic carbonate. Under this treatment the patient rapidly improved in health and strength. The night sweats ceased in a week and the patient gained in weight. The smaller ulcer healed in two weeks, the larger decreased but remained open for six weeks, at the end of which time a piece of the vomer, triangular, and extending 6 mm. (quarter of an inch) upon each side, became loose and was extracted through the ulcer. The patient was soon well and has remained so, under observation for three years, up to the present time.

CASE 7.—Mrs. A., aged 50, the buxom widow of two husbands, came from the country to consult Dr. Wigglesworth for a perforation of the soft palate rather larger than the end of a Faber's lead pencil. No prior sensations except a slight abnormal feeling in the fauces for a few days, and a small "hump" perceptible to finger and eye about the centre of the soft palate, on a line with the uvula. No pain. Some little difficulty in swallowing.

Found on rising one morning that she "talked through her nose, and part of her breakfast went up instead of down." Examination showed a complete perforation with clear cut-edges; at present her hearing is good, voice not specially nasal, no pain, deglutition causes some annoyance. The perforation is about the same size as at first. There are no signs of scrofula, and patient has always been "strong as the best of them."

She expressed doubts as to the general physical condition of her second husband, but is reticent as to details and admits nothing as regards herself. In such a case, however, no history is needed. The ulceration was swabbed once with a saturated solution of nitrate of silver. Then iodoform, made into a paste with

alcohol and glycerine, was inserted, upon a plug of surgical cotton, into the aperture, and the patient was directed to renew it three times a day after meals. One gramme (fifteen and a half grains) of potassic iodide in a *cup* of water, three times a day *between* meals, and half a teaspoonful of the syrup of ferric iodide, with each meal, *after the first few mouthfuls of food*, in a *sherry-wine glass* of water, were given internally. Dry baths (*i. e.*, friction), fresh air, and exercise, strong diet, regulation of all the bodily functions, etc., were of course insisted upon.

Four days later the patient reappeared to say that she was going home. The perforation was closing fast. She continued treatment, and seven days later, eleven from the day when she was first seen, word was received that there had been "no more signs of the hole for some days. Every thing here favored rapid recovery, still the case shows what may be done by combining suitable remedies in sufficient amounts and attacking simultaneously along the whole line.

CASE 8.—Edw. M., æt. 27. From June 23d to July 3d, 1880, was in company with one woman, and had been with no other for two months previously.

July 5th.—Noticed small chafe on exterior of penis and a small scab, which healed under treatment in six days. No roseola nor alopecia was noticed, no headaches nor pain in bones.

Dec. 1st.—Noticed pain and difficulty in swallowing; has observed nothing else to date.

Jan. 5, 1881.—On examination scar is visible on penis; no induration of inguinal glands, but some of cervical. In the region of the niche over the left tonsil a deep ulcer is found; this is nearly hemispherical about $1\frac{2}{3}$ cm. (two thirds of an inch) in diameter, and 1 cm. (four tenths of an inch) deep, seated in thickened tissue.

The periphery is regular, punched out with grayish-yellow secretion, showing fundus in places; this latter is apparently formed of muscular tissue.

Treatment.—Potassic iodide with mercuric bichloride internally, and iodoform in powder locally.

Jan. 7th.—Somewhat better.

Jan. 14th.—Ulcer is smaller and shallower, with a redder base, which is clear, and covered with minute granulations; pain has disappeared.

Jan. 22d.—Ulcer filled up to a level with healthy granulations,

throat otherwise natural ; patient feels strong and well ; treatment continued.

Feb. 6th.—Ulceration wholly cicatrized.

CASE 9.—Lizzie W., æt. 42, had an illegitimate child twenty-three years ago ; the infant had “ snuffles ” soon after it was born, but no eruption, and died of consumption in its sixteenth year. Indistinct remembrance of glandular abscesses in groin at intervals after birth of child. No eruption remembered ; frequent attacks of quinsy. Last August throat became sore in region of soft palate ; patient had treatment outside the hospital during several months, both by gargles and “ for the blood ” ; used also Wei de Meyer’s catarrh snuff.

Feb. 2d. On applying at hospital there is seen on soft palate and base of uvula a triangular, deep, inflamed ulcer ; edges irregular and steep, areola red ; base uneven, gray, smeary ; secretion scanty. Small spots on pharyngeal posterior wall are ulcerated. Touched with stick argent. nitratis.

Feb. 7th. Ulceration larger, spreading over half of uvula, cutting through part of base of uvula upon the right side ; elsewhere some few granulations are visible. Small ulcerations have appeared around the large one.

Locally, iodine spray and iodoform daily ; potassic iodide and corrosive sublimate internally, with cod-liver oil.

Feb. 9th. Ulcer no larger, granulations in centre more abundant, pharynx much as at first.

The small yellow ulcers visible last time around main ulcer are not changed ; secretion more abundant and purulent ; areola less inflamed. Complains of pains in vault of cranium on lying down ; these are relieved by potassic bromide.

Feb. 15th. Ulcer granulating well ; spots in pharynx and in periphery of ulcer are all healed. Much secretion is washed out of ulcer by the iodine spray, which causes slight bleeding from the granulations.

Feb. 25th. Floor of ulcer level with surface of surrounding mucous membrane, from which cicatrization is rapidly extending. Corrosive sublimate now omitted.

March 1st. Ulcer entirely healed, general health much improved.

CASE 10.—Victor M., æt. 42, gives a clear history of syphilis contracted seven years ago, and treated with apparent success by mercuric protiodide.

On examination, January 19th, the anterior third of the tongue was enlarged and bright red ; showing hypertrophy of papillæ, slight in centre, much greater at the sides.

Superficial aspect pearly, underneath purplish, edges corrugated, worm-eaten, ulcerated. Ulcers with overhanging edges, indented like the teeth of a comb, not much secretion. End of tongue is square, not pointed ; sides papillomatous ; depressions showing neither granulations nor marked secretion. Great pain on left side of tongue, where it rubs against the teeth.

Glands on right side of neck much enlarged, left side of neck hugely swollen, inflamed, and about to suppurate. Admitted to hospital January 19th. The abscess when opened discharged 130 gms. (about four ounces and a half) of pus. Treatment by potassic iodide, iron, and tonics.

Feb. 21st. Abscess healed ; some discharge from an opening on the right side of the neck. Tongue in previous condition, perhaps not quite so large ; not so many ulcerations, but one rather large one in left anterior corner. Treatment continued with use of iodoform locally.

March 14th. Abscesses all healed, ulcer on tongue filled up to a level by granulations, but not wholly cicatrized. Some spots in periphery of ulcer are yellow, and apparently about to break down. The patient subsequently removed to another city.

CASE 11.—John M., æt. 23, was in hospital in April for ulceration of throat and inability to swallow, at which time his lungs were found to be somewhat diseased. In August went to the dispensary where an ulcer in his palate was cauterized. This healed leaving a scar—not tendinous nor star-shaped.

In December ulcers again formed, now in left fauces, upon anterior pillar and tongue, in niche and on posterior pillar ; also on right side at root of posterior pillar ; cannot swallow solid food ; breathing somewhat noisy.

Dec. 26th. The ulcerations are elongated, superficial, non-inflammatory, in lateral rather than median region of throat ; the edges are irregular and poorly defined, the base pale and unhealthy. The secretion thin, scanty, grayish. The larynx is much swollen ; one arytenoid cartilage is immovable. The cords are ulcerated. Diagnosis : Tuberculosis of fauces and larynx, with perichondritis of larynx. Incipient phthisis in the lungs. There is no history nor lesion indicating syphilis, except the scar on the palate. Cod-liver oil and tonic treatment were given.

Ulcers were touched with silver nitrate, two per cent. solution, thus relieving the sensitiveness.

Jan. 17th. New ulcerations of similar nature had formed around margins of old ones. Pulmonary symptoms worse, strength failing. Larynx not visible but more painful. Prognosis evidently very unfavorable.

It is not always possible to diagnosticate the malady causing ulcerations of the mouth or throat, the local pathological condition being practically the same whatever may be the underlying constitutional disease; viz., an enormous amount of small cells, packed so closely that they cut off the sources of nutrition. The age of the patient, the history, and the presence of other symptoms must be taken into account, and, finally, it is sometimes necessary to suspend judgment until the failure or success of remedies clears up the nature of the case. Nevertheless, in very many instances a diagnosis may be made at sight, and sometimes it is very important to avoid asking questions. The syphilitic ulcer may be, first, a sloughing gumma, round or nearly so, deeply hollowed or punched out, situated in thickened tissue—usually of the palate, palatine arches, or uvula,—with gray, adherent secretion, without granulations, and with an inflamed areola. The gummata may be large or small; in the latter case they may be confined to the mucous membrane, and are then sometimes called syphilitic tubercles; large gummata are very apt to penetrate to the muscular layer or to the periosteum of bones and are therefore very destructive, often involving the bones of the nose and hard palate, sometimes even of the base of the skull; in either case the microscopic condition is the small-cell infiltration, aggregated into definite, more or less globular, masses of various sizes.

Occasionally, however, this infiltration is not limited, but diffuse, occupying considerable tracts of tissue, such as the whole of the soft palate, or one or both of the palatine arches. In the same way the vault of the pharynx, the nasal structures, or the larynx may be invaded. This condition, known as œdema, or hyperplasia, is insidious and very dangerous, for it may suddenly give rise to rapid

destruction of large tracts of the tissues, a so-called melting, or liquefaction, which is neither arrested nor benefited by immediate cauterization, although constitutional treatment appears to rapidly improve the condition of the partially infiltrated adjacent tissues. The appearance of such ulcers is characteristic ; in a brawny, indurated, swollen tissue is a deep, steep, ragged ulceration, with adherent, gray, sloughing base ; no attempt at granulation ; a red areola ; very little or no pain ; and much less difficulty in swallowing than one would expect. But as the extent, depth, and density of the infiltration is variable, of course not all syphilitic ulcers are so well marked ; they may be more indolent and hard, resembling epithelioma ; or serpiginous, shallow, and irregular, simulating tuberculous ulcerations ; and in some cases it is impossible to make a diagnosis merely from the local appearances ; the history and other symptoms must be considered, and also the rapidity and course of the ulcerative process, the action of remedies, and the final result. It is very seldom that the mistake of confounding this condition with epithelioma can be made after ulceration has set in ; the syphilitic ulcer tends to assume a circular form, while epithelioma shows deep, irregular excavations and hard, projecting vegetations which are wanting in syphilis and tubercle. The adjacent tissues in epithelioma are usually harder and thicker, the progress slower, and the results always unfavorable, therapeutics being powerless to arrest the march of the disease (unless we can credit the claims now made for Chian turpentine) except by wholly removing the affected parts. Tuberculous ulcerations occur almost always in persons who are otherwise tuberculous, or at least reveal a tendency toward phthisis, or have a history of it in the family ; the ulcers attack chiefly the tongue and posterior wall of the pharynx, or the larynx. Syphilis appears oftenest in the hard or soft palate, uvula, palatal arches, epiglottis, and larynx proper. Tuberculous ulcers are chronic, lasting from six months to more than a year, slowly spreading, hardly ever healing. They are quite painful, cause a great flow of saliva, and rarely occasion swelling of the neighboring glands. They are more super-

ficial than those of syphilis; the adjacent tissue is less thickened, and often pale, although the immediate border of the ulcer is red. Finally, careful inspection usually reveals small grayish-yellow spots near the periphery, which are aggregations of miliary tubercles about to break down into minute ulcers. When this occurs these spread, coalesce, and finally unite with the original ulcer, causing a most irregular outline; treatment is useless and death occurs sooner or later from general tuberculosis. Of lupus, or scrofulous ulcers, it may be said that they sometimes resemble syphilis very closely, and, unless there be some other manifestation of lupus, it would be hard to find any clearly diagnostic points of difference; they may perforate the hard or soft palate, or may destroy the nasal structures, thus simulating syphilis very closely; so that if any history of the latter was found, they would be reckoned among its symptoms. They do occur, however, when there is no history nor reasonable suspicion of syphilis, and this fact must be remembered before expressing an opinion that may do irreparable damage to an innocent person. Potassic iodide seems to have little or no effect on them, but iodine spray, ferric iodide, cod-liver oil, and fresh air, with good food, suffice to cure them.

In regard to the treatment of syphilitic ulcers it may be said that stimulant are far better than caustic applications. The latter are only useful in hastening the destruction and separation of parts of the circumference of ulcers, which parts are evidently doomed to perish. In general, it may be said that an over-use of caustics is the customary treatment of such ulcers, judging by their history and condition when seen at the hospital. It is very seldom that the tissues fail to respond immediately and favorably to the treatment with iodine spray and iodoform about to be described, combined with constitutional medication.

Ulceration is arrested immediately; the unhealthy pus is washed out from between the granulations; the smeary, gray, sloughy bases clear up; and in a few days the whole ulcer is covered with fine, red granulations, which bleed slightly under the influence of the spray.

Prodigious amounts of unhealthy secretion are sometimes brought away from the vault of the pharynx and the posterior nares to the great relief of the patient and to the great improvement of his digestion and nutrition, while at the same time the fetor of the breath is abolished.

The customary strength of the solution used for atomization is $\frac{1}{3}$ th the strength of tr. iodine; or, tr. iodine 5 parts, glycerine 10 parts, water 30 parts.

The most convenient instrument to use is that known as Fulgraffe's, which is made of hard rubber, with nozzles of various shapes,—one to send a stream of spray up behind the soft palate, one for a horizontal stream, and one for use in the larynx. The bottle should be kept nearly full, in order that the stream should not be kept up longer than is intended, owing to compressed air remaining in the bottle. The spray is formed by driving a mixture of air and fluid through a narrow opening. Three or four applications of twenty seconds each will be sufficient to thoroughly cleanse and stimulate any ordinary ulcerations.

After the use of the spray, iodoform should be applied to the ulcer with a camel's-hair pencil, or blown on to it either by an ordinary insufflator or by a bottle connected with two glass tubes, one of which is attached to a hand-ball or mouth-piece and passes below the surface of the cork, while the other, starting below the level of the powder, is bent so as to conveniently carry the cloud of air and powder to the surface of the ulcer; a little powdered gum arabic mixed with the iodoform makes it adhere better. By this means the physician avoids handling the powder and scenting his hands or clothing. Iodoform can also be conveniently deposited on the nasal mucous membrane by letting the patient inhale a saturated solution of the drug in ether.

Some cases require the use of the nasal douche with disinfectants. A convenient formula is: one teaspoonful of chlorate of potash, with $\frac{1}{3}$ d as much carbonate of soda or salaëratus, and 15 drops of a five-per-cent. solution of permanganate of potash, all in a quart of water at 25° centigrade (77° Fahrenheit), used with a fountain syringe. It is well to remember that a spray or a powder carried by a cur-

rent of air may be used by blowing it into one nostril while the patient breathes through the open mouth. The spray then passes through the vault of the pharynx and escapes by the other nostril. If desirable, by instructing the patient to breathe through the nose, a powder may be blown into the larynx through the nostril.

Of course constitutional treatment is of vital importance; it is hardly necessary to discuss it here, except to emphasize the fact that these deep ulcerations occur late in the course of the disease, from two to twenty or more years after the primary infection, usually in cachectic individuals.

Mercury, therefore, plays a less important part in the treatment than iodine and its compounds: cod-liver oil, ferric iodide, potassic iodide, iodine spray, iodoform,—these are the great remedies, and it is only in rather robust individuals, especially where mercury has never been used sufficiently or properly, that .005 (one twelfth of a grain) to .003 (one sixteenth of a grain) gramme of mercuric bichloride or biniodide, given before meals, in five grammes (one drachm and a quarter) of wine of iron, will prove of advantage. Exercise, fresh air, good food, and cleanliness must not be forgotten, and if all these means be suitably employed, the most frightful syphilitic ulcerations will usually heal with surprising rapidity. The diagnosis of lupus is of less importance, practically, than might be supposed, inasmuch as the treatment is nearly identical with that for syphilis. Cauterization may, however, be used more freely, especially where any peripheral deposits are detected. Mercury is injurious; cod-liver oil is of the greatest efficacy; and the local iodine treatment, with ferric iodide internally, gives excellent results.

Those desperate cases remain to be considered in which tuberculosis of the throat has led to ulceration, and, as in these cases the lungs are also speedily involved, the prognosis is unfavorable from the beginning. The same may be said of cases in which syphilis has been contracted by persons already decidedly phthisical, or where the cachexia of syphilis, added to privations or injurious modes of living, has led to pulmonary tuberculosis. In such cases the ap-

pearance of deep ulcerations of the throat is an ominous symptom. It is idle to discuss the question whether such ulcers are tuberculous or syphilitic; the two conditions do not exclude each other, their local symptoms are microscopically nearly identical, their combination is practically fatal.

The prevention of venereal diseases.—The following is an Act prepared by the American Public Health Association, to be presented to the Legislature of Maryland :

ARTICLE I. Be it enacted by the General Assembly of Maryland, That any person who shall knowingly communicate, or be instrumental in communicating, by any direct or indirect means, a contagious disease, such as small-pox, scarlet fever, or venereal disease, shall be deemed guilty of a misdemeanor, and shall be subject, upon conviction in any of the Circuit Courts of the counties of this State, or in the Criminal Court of the city of Baltimore, to a punishment of six months' imprisonment in the House of Correction of Maryland.

ARTICLE II. Be it further enacted, That if any person being the owner or occupier of any house, room, or place, within the limits of this State, having reasonable cause to believe any person to be affected with a contagious disease, induces or suffers such person to remain, or be at that house, room, or place, he shall be deemed guilty of a misdemeanor, and on summary conviction in one of the Circuit Courts of the State, or in the Criminal Court of the city of Baltimore, shall be liable to a penalty not exceeding one hundred dollars, or, at the discretion of the Circuit Courts of the State, or of the Judge of the said Criminal Court, be imprisoned in the County Jail of the county in which conviction takes place, or in the Baltimore City Jail, for any term not exceeding six months.

ARTICLE III. And be it further enacted, That the State Board of Health, with the approval of the Governor, and the Health Board of the city of Baltimore, with the approval of the Mayor, shall have power to remove to a hospital or hospitals all persons suffering from contagious diseases, who, from failure to take proper precautions, imperil the health of the community.

ARTICLE IV. And be it further enacted, That this Act shall go into effect on the first day of June, eighteen hundred and eighty-two.

ON AN UNUSUAL EFFECT OF THE SULPHIDE OF CALCIUM.*

By W. T. ALEXANDER, M.D., NEW YORK.

SINCE the re-introduction to professional notice, by Ringer, Cane, and others, of the sulphide of calcium as a remedy for pustular acne, furuncles, and other suppurative processes in the skin and glands, testimony as to its merits in these affections has been furnished by a large number of observers. The usual effects of the drug are so familiar to the members of this Society, several of whom have furnished valuable communications on the subject, that it would be presumptuous in me to enter into their discussion in this place. But, in a very small number of cases that have recently come under my observation, the agent has seemed to exert an action so different from that usually ascribed to it in text-books and communications to journals, that they seem sufficiently interesting to justify me in briefly reporting them.

CASE 1.—A physician, aged about twenty-six, who had had for a number of years an acne vulgaris of the face, undertook to treat himself for it with the sulphide of calcium. In consequence of a misapprehension as to the appropriate dose, he took eight grains of the drug three times daily, for several days. During this time his acne not only became worse, but several large, highly inflammatory, and exquisitely sensitive furuncles appeared on his wrists, forearms, and neck, attended with moderate febrile movement, gastric disturbances, and diarrhœa. On being informed of

* Read before the N. Y. Dermatological Society, Tuesday evening, Dec. 27, 1881.

his mistake concerning the dose, he stopped taking the sulphide, and the furuncles began at once to improve, becoming less painful, losing their inflammatory areolæ, and the previous slight purulent discharge from them ceasing. He entirely recovered in a short time without treatment.

CASE 2.—The wife of a physician was much annoyed by a small indolent, painful, abortive furuncle on the back of the neck. She was ordered to take the bisulphide of calcium in doses of one tenth of a grain, four times daily. After she had done this for a few days, several large, intensely inflammatory, and very sensitive nodules appeared on the face, arms, and other parts of the body, causing considerable suffering, and attended with slight constitutional disturbance. As these symptoms were held to be simply manifestations of the original disease, the use of the drug was persisted in, it being given in increasing doses. As long as this was done, the furuncles became larger and more painful, until, finally, the patient having lost faith in the remedy, its use was abandoned, and she began to improve almost immediately, and was soon entirely well, slight suppuration having occurred in most of the lesions.

CASE 3.—A man, aged 33 years, who had suffered at intervals for a number of years from small furuncles on the head, face, and different parts of the body, presented himself for treatment, during a mild attack of the affection, at the clinic of Dr. Bulkley at the New York Hospital. He seemed a delicate, badly-nourished man, suffered from habitual constipation, and presented a few small indolent furuncles on the scalp, forehead, and back of the neck, none of which caused much pain. He was ordered the sulphide of calcium, in pills, containing one fourth of a grain each, to be taken four times a day, and a laxative mixture. After following this treatment for one week, but little change had taken place in the furuncles which previously existed, and a new one, much more inflammatory and sensitive than the others, had formed in the palm of the left hand. The former treatment was stopped, and he was ordered a mixture of arsenic and iron. Three days later slight improvement was manifested in the general condition, but this not being maintained at the time of his next visit, and the furuncles (which had undergone but little change) again causing him slight discomfort, he was ordered to take the pills of sulphide of calcium again.

One week later, the patient having taken the medicine steadily

during the interval, his condition was much worse than at any time before. A large number of furuncles had made their appearance on the face, arms, and fingers; seated on the latter, on the palmar aspect of the first phalanges. They seemed to have originated deep down in the tissues, as if in the sheaths of the tendons. The whole hand was greatly swollen and slightly œdematous, and the finger was exquisitely sensitive to pressure around the furuncles, which were surrounded by a broad inflammatory blush, and, as a rule, discharged a small quantity of thick pus from fine openings at their apices. The fingers were semiflexed, and attempts to straighten them gave the patient great pain. Marked febrile reaction was present, the patient was unable to sleep, had no appetite, and suffered from alternating chilliness and heat. It seeming probable that the trouble was due to the sulphide of calcium, which he had been taking in increasing doses daily, he was ordered to stop it, and was given small doses of quinine, opium to relieve the pain, and a cathartic mixture. Poultices were also ordered to the hands and fingers. Three days after beginning this treatment immense improvement was manifested in the case. All œdema of the hands and fingers had disappeared, the furuncles were discharging pus freely, the pain, fever, and chilliness had ceased, and the patient made a rapid recovery, having no furuncles on his body when last seen.

That the pathological phenomena in these cases were not simply coincidences, but were due to the action of the sulphide of calcium, is rendered almost certain by the fact that recovery began in each of them immediately after the use of the agent was suspended. That they are not instances of drug aggravation is also rendered probable by the fact that in none of the cases was there any evidence of suppurative action in the skin before taking the medicine, and that this was a prominent element in all three of them after it had been taken for several days.

Abundant testimony can be found showing the value of this agent in suppurative diseases, particularly occurring in the skin and its appendages, but that it is capable of *causing* such affections has been stated, as far as I know, by only one author, Hahnemann, who says, that taken internally it may cause the formation of vesicles, pustules, and

furuncles on the healthy skin. In view of its generally admitted efficacy in relieving these conditions, and granting that in the three cases cited it really was the cause of the pustules and furuncles, the question might be asked, do they not furnish an illustration of the truth of the well-known homeopathic law, conversely stated, that remedies which relieve given conditions are capable of producing them in healthy persons, when given in large doses? This question must logically be answered in the negative, for aside from the fact that the number of cases is too small to warrant any deductions leading to the affirmation of a general law, the circumstance that the drug under consideration produces no such effect in the large majority of cases in which it is used, shows that it can by no means be regarded as characteristic of its normal action. I have myself used it in a large number of cases, and seen it used in more, and in all, the effect was either negative or decidedly beneficial, although it was taken steadily for a long time in many cases, and sometimes to the extent of one or more grains daily.

The most reasonable explanation of the pathological changes in these cases seems to be to attribute them to the influence of that indefinite and undiscoverable quality known as individual idiosyncrasy, or susceptibility to the perverse action of a particular agent, occasionally observed in practice.

A CASE OF XANTHOMA TUBERCULOSUM ET STRIATUM.

By GEORGE HENRY FOX, M.D.

XANTHOMA is a cutaneous disease of such rare occurrence, save upon the eyelids, that any case presenting more or less variation from the description usually found in the text-books deserves to be placed on record.

In June, 1881, a lady was sent to me for examination, who presented a peculiar form of xanthoma which I had never before observed. From my brief notes of her case I am able to report the following:

Mrs. —, æt. 32. In average good health, and exhibiting a decided tendency to corpulency. Has never suffered from jaundice or any other hepatic affection, but is subject to occasional attacks of "sick headache." Upon her lip and chin a marked tendency to hirsuties is observable. She states that about a year ago her attention was first drawn to a slight change in the condition of her palms, the natural creases of which having grown lighter in hue than the surrounding skin. In the course of a few months numerous small yellowish nodules made their appearance just below her elbows. These occasioned neither pain, itching, nor other subjective sensation, and she consulted me, at the request of her physician, to ascertain, if possible, the cause of the peculiar change in the character of the skin. An examination of the palmar surface of the hands, the web of the fingers, the anterior aspect of the wrists, the bend of the elbows, and the axillary folds, showed that the skin had assumed a pale yellowish or light ochre hue in the natural creases, and when the parts were extended this peculiar striated condition became very apparent.

Upon the extensor aspect of the forearms, just below the elbows, there were symmetrical groups of yellowish tubercles. These lesions were numerous, closely set, though not confluent, of the size of hemp-seeds and of the color of chamois-skin. One of these tubercles, which the patient allowed me to dig out with the dermal curette, appeared to the naked eye as a small hard globular mass. The eyelids of this patient were unaffected. I saw Mrs. — six months later, at which time there was no apparent change in the condition of the skin. The yellow tubercle which I had dug out had not been replaced by another, and a small white scar occupied its place.

The two varieties of xanthoma which are usually described are *X. planum* and *X. tuberosum*, the affected skin presenting the form of smooth and slightly elevated patches or tumors of the size of a pea and larger. I have no desire to add to the already extensive nomenclature of dermatology, but neither of the above-mentioned terms are exactly applicable to the case which I have briefly described. The lesions upon the elbows were tubercles, and not tumors, as the term *tuberosum* would imply; and as for the peculiar condition of the flexor aspect of the joints, I know of no term which could be more expressive than *xanthoma striatum*.

Clinical Reports.

CLINICAL ILLUSTRATIONS OF DISEASES OF THE SKIN.*

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VIII. Scabies.—Synonym: *The itch*.

The last of the parasitic diseases is that caused by the presence and burrowing of the insect called the *acarus scabiei*, known also as the *sarcoptes scabiei* and *sarcoptes hominis*; the popular term for the eruption, namely, "the itch," is expressive of a marked feature in the state, but the name is less applicable to it than to eczema, for the itching of scabies is sometimes spoken of as pleasant, if moderate scratching is indulged in to allay it, whereas the itching of eczema is often torture.

Scabies is a comparatively rare disease in this country. Among 8,000 miscellaneous skin cases of my own recently analyzed, it formed only four hundredths of one per cent. in the private, and something over two per cent. among public cases, or about one and

* The very favorable reception which was accorded to the "Notes on the Local Treatment of Certain Diseases of the Skin," until most of the diseases which are at all common were gone over, in previous issues of these ARCHIVES, leads the editor to continue this plan of serial writing for general practitioners in the form of "Clinical Illustrations of Diseases of the Skin." It is intended in these to give plain and practical comments on dermatological subjects, based on illustrative cases taken from private and public practice, some of the matter at times being that delivered in clinical lectures at the New York Hospital. The diseases will, as far as practicable, be treated of in the order in which they occur in the Classification commonly found at the beginning of the Digest Department. These notes are continued from pages 60, 139, 261, and 399, volume vi; and from pages 162, 301, and 403, volume vii.

one half per cent. for all classes of society. Occasionally, however, it appears in public institutions, and many cases are seen together, which would greatly increase this percentage if these were seen and included. In some countries, as in Scotland, it is very much more frequently met with, and in statistics from Glasgow it forms about twenty-five per cent., or a quarter of all cases. During our late war it was much more common, and was often spoken of as "army itch," but as far as was demonstrated these cases were only aggravated instances of scabies, often long neglected.

The degree of severity of the eruption in scabies varies very greatly in different cases, and depends on the condition of the individual, the duration of the disease, and the treatment or care of the skin, and cleanliness. Beginning often with the burrowing of a single impregnated female, cleanliness may prevent many of the young which are hatched out of the furrow from burrowing again, and but a few papulo-vesicles are formed; these generally appear first in the spaces between the fingers, because here the skin is tender, and the insects are more likely to be undisturbed. The disease may thus be confined to a limited area for a considerable period, and if the individual be in perfect health, very slight inflammation is caused at the seat of entrance of the insect, as in the following case:

E., aged 26, had experienced itching of the hands for several weeks, and when first seen, February 22, 1872, exhibited abundant marks of scratching on the hands and forearms. On close examination a number of vesicles were seen on the hands, and several *cuniculi* or furrows caused by the acarus, appearing as minute blackish, curved lines just beneath the skin, as though a bit of dark sewing silk had been run under the cuticle.

He was ordered a warm bath, and subsequent firm friction with the following ointment, which was to be left on the skin a full day without washing, and repeated if necessary: \mathcal{R} Bals. Peruv., $\bar{\zeta}$ ss; sulph. precip., $\bar{\zeta}$ ss; potass. carb., $\bar{\zeta}$ ii; unguent. simpl., $\bar{\zeta}$ iii; \mathcal{M} . When next seen, two weeks later, all traces of the eruption were gone.

More commonly, however, when presented for treatment the condition has existed for some time, and a multiplicity of lesions are visible upon several regions, and the locations which are affected are generally characteristic of the disease. These are, in addition to the hands, especially the spaces between the fingers, the wrists, and forearms, the anterior fold of the axilla, the penis, the region of the female nipple, the buttocks, and about the ankle and sole of the foot in children.

The following case exhibits the features of the eruption, as commonly presented by a case which has existed some time :

J. A., aged 28, after a trip around the world, came to me September 4, 1879. Three months previous, when a week on the steamer from Yokohama to San Francisco, he noticed an itching about the genitals and thighs, which remained and increased until the time of his visit, affecting much of the body. He had been variously treated in the West on his journey to New York, but with very little relief, the diagnosis of scabies not being made.

On examination, much of the body and limbs, as also the penis, was the seat of a papular eruption and scratch marks, the forearms being considerably torn ; the penis had a number of large papules, some surmounted with crusts. The hands, especially the interdigital spaces exhibited papules and some vesicles ; and the minute, dotted, and curved lines of the cuniculi were clearly visible, although not in great numbers. He was ordered a thorough friction with the *sapo viridis*, then a warm bath for half an hour, and a subsequent thorough inunction with the following ointment : \mathcal{R} Olei cadini, \mathfrak{z} iii ; sulph. precip., \mathfrak{z} iii ; cretæ preparat., \mathfrak{z} ii ; saponis viridis, unguent. aquæ rosæ, aa, \mathfrak{z} i ; \mathfrak{M} . This was to be well rubbed into the skin, especially in the regions previously mentioned as commonly affected, and was to remain on the skin for twenty-four hours.

Two days later, September 6th, it was recorded that all itching had ceased, and many of the lesions had disappeared. There were still some unbroken vesicles upon the fingers ; he was directed to rub in the ointment again twice, using pumice-stone to the hands if necessary to break the vesicles, to sleep in the ointment, and to take a warm bath the next day, and to follow this by a sulphur vapor bath, as he was very desirous of being absolutely freed from his trouble before returning to his family. The very active treatment employed resulted in some inflammation of the skin in places, especially on the penis and scrotum, where there had been lesions of some size, but these ceased upon the use of oxide of zinc in rose ointment.

The possible occurrence of scabies in patients affected with other skin lesions must ever be remembered, for when this complication exists it can only be met by appropriate and intelligent treatment ; and if the true nature of the new eruption is not recognized, much confusion may exist as to the preceding eruption ; I have thus seen scabies in patients with psoriasis, syphilis, eczema, etc. The following case illustrates this point :

Mr. C., aged 29, consulted me September 7, 1871 ; he had previously been under the care of the late Dr H. D. Bulkley, for secondary syphilis, and was surprised at what appeared to be a

new phase of his disease. For ten days previous to his visit he had experienced great itching, especially about the abdomen and thighs, and he had scratched considerably for relief. On examination a number of excoriated papules were seen about the abdomen and thighs, also upon the forearms, while upon the penis were seen several characteristic shotty, inflammatory lumps, slightly excoriated on the surface, and with some indistinct furrows leading to them. Between the fingers and on the flexor surface of the left wrist there were also inflammatory lesions, but no furrows were found here, as he had scratched violently. He was ordered thorough friction in a bath, and the following ointment was directed to be very freely applied and rubbed in after it, and to be left on the skin: \mathcal{R} Olei cadini, $\frac{3}{4}$ ss.; sulph. precip., potass., carb., aa, \mathfrak{z} ij; unguent. aquæ rosæ $\frac{3}{4}$ iv; \mathfrak{M} .

Remarks.—While scabies has been shown to be comparatively infrequent among the better classes, it is still occasionally met with, and care should be always exercised to recognize or exclude it, when symptoms are presented which suggest this cause of the eruption, inasmuch as without proper and sufficient treatment it may linger for a great length of time; if, on the other hand, treatment for this is employed when it does not exist, not only is there no benefit, but a previous eruption is aggravated. It sometimes happens that on a mistaken diagnosis an eruption of eczema or lichen is treated as scabies, and the continued aggravation of the itching causes an increased severity of treatment until a very great amount of artificial eruption may be induced, and the correct diagnosis is thus still further obscured. It also not infrequently occurs when scabies is present, that after the parasite has been destroyed there still remains a certain amount of itching, either from an eczematous habit, or urticarial influence, or other reason, and this being mistaken for an aggravation of the former disease, the irritating parasitic applications are still employed, and perhaps yet more severely, to the still greater irritation and inflammation of the skin. After the treatment, therefore, a little time should elapse, and a soothing alkaline and starch bath be taken, in order that the skin irritation may subside; this is further aided by the subsequent use of carbolized cosmoline, five to ten grains in the ounce. Over-treated cases of scabies are sometimes very annoying.

The only pathognomonic sign of scabies is undoubtedly the presence of the acarus, either demonstrated as taken from a furrow or vesicle, or in lieu of it the furrow or *cuniculus* is equally an indication of the presence of the insect. But often this latter

has been removed, or so broken up by previous treatment or scratching that distinct ones cannot be made out ; often also the insects have not burrowed long enough to cause the minute lines, but immediately on their entering the skin an irritation is set up which leads to papules, vesicles, or pustules. In acutely sensitive skins this is often the case, while in sluggish, strumous subjects the tracks of the burrowing insect may be very abundant, large, and long.

Occasionally it happens that the edge of broken vesicles of eczema, or perhaps even of scabies itself, may very closely resemble these blackish lines presented by the cuniculi ; but a little care, and a little washing will show their true nature, the edge of epidermis being lifted up, and the dark color disappearing as the minute accumulation of dirt is removed by washing ; the furrow of the insect is unchanged by moderate cleansing, or rather is brought out into more distinct prominence. Some cases of eczema of the fingers and hands are very difficult to distinguish from scabies.

While the *cuniculus* is, as stated, the sure sign of the presence of the acarus, the existence of the disease can generally be made out by other indications. Rarely does one case occur alone, but frequently the source of infection is already known, and generally more than one member of the family is affected, especially if there are children. The location and the character of the eruption on the flexor surfaces of the wrist, penis, anterior folds of the axillæ, are also striking, and a general study of the distribution and characters of the lesions can usually, if care be taken, suffice for an absolute diagnosis.

A CASE OF TINEA VERSICOLOR IN A CHILD.

BY WALTER G. SMITH, M.D., DUBLIN,

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The great majority of cases of tinea versicolor are unquestionably observed in young and middle-aged adults, and the fact of its occurrence at an early age is not recognized by most authorities.

For example, Dr. L. D. Bulkley writes : "Tinea versicolor is a disease of middle life ; * * * it is doubtful if it ever appears

before puberty ; several of the cases dated back to about fourteen years of age." (ARCHIVES OF DERMATOLOGY, July, 1881, p. 300.) And, again, Mr. Malcolm Morris teaches that "tinea versicolor does not occur in childhood." (*Manual of Skin Diseases*, p. 275.)

Hence I am induced to send to the ARCHIVES a brief note of a case that came under my observation in the Adelaide Hospital in March, 1880.

A little girl, aged 12 years, with dark hair and gray irides, was admitted into hospital for an attack of measles.

When convalescing from the measles I observed with interest that she was affected with an extensive eruption of tinea versicolor. The disease was widely spread over the chest, but was also plainly visible on the back. For the most part it consisted of small, dark brown spots and patches, with abundant branny desquamation, but was not itchy. Over the sternal region the eruption was confluent. When the disease first appeared could not be ascertained, but the girl was positive that it had existed for a long time

Sir Erasmus Wilson.—Dermatology has been honored in the knighthood of Erasmus Wilson, who has munificently erected a new wing and chapel to the Margate Sea-Bathing Infirmary, at a cost of nearly \$150,000. He had previously given \$50,000 to transport and erect the obelisk on the bank of the Thames, and \$2,000 to endow a chair of Dermatology in the Royal College of Surgeons of England, at the same time donating to the College his collection of models, etc., illustrating the subject. As President of the Royal College of Surgeons, and President of the Dermatological Section of the International Medical Congress, he gave a handsome reception at Margate ; also a dinner to the members of the Section.

Dermatology at Vienna.—KAPOSI has charge of Hebra's Dermatological Clinic, and NEUMANN has just been given charge of the Clinic for Syphilis in the Vienna University.

Society Transactions.

DERMATOLOGY AT THE INTERNATIONAL MEDICAL CONGRESS

Held in London in August, 1881.

PREPARED BY DR. T. COLCOTT FOX.

The meeting in London last August was undoubtedly of great importance and of much value, from many points of view, for those specially interested in the study of diseases of the skin. In the first place, the specialty was given a recognized position, and there has probably never been a meeting together of so many dermatologists before from different countries and at the same time of such a representative character. Secondly, the meeting unquestionably has advanced dermatology yet another stride, whether we regard the really solid advantages gained by the reading of the many important papers and the ensuing discussions, or the rare and interesting cases brought together for observation, or the collections of drawings, specimens, and models from various collections in the museum. And lastly, but not least in value, were the interchange and comparison of views and suggestions in many conversations, the observation of the modes of treatment carried out in the London clinics, and the increased interest in other work which must result from making the personal acquaintance of different workers in other parts of the world. We think the exhibition of living cases was especially appreciated and was of the highest interest, and only regret that more time was not set apart for this purpose. To English dermatologists it was not the least of the gratifications afforded them that the meeting was presided over by that veteran worker, now Sir Erasmus Wilson, the President of the Royal College of Surgeons of England, inasmuch as the cultivation of this branch in England has never been encouraged as a specialty, and has long been neglected except by a few. From whatever point of view we re-

gard the meeting, then, it was unquestionably a great success. The following is the list of the English Council formed to conduct the proceedings :

PRESIDENT,

ERASMUS WILSON, F.R.S., London.

VICE-PRESIDENTS,

Dr. CHEADLE, London,

Dr. R. LIVEING, London.

COUNCIL,

MORRANT BAKER, Esq., London,

Dr. A. JAMIESON, Edinburgh,

Dr. RADCLIFFE CROCKER, London,

Dr. STEPHEN MACKENZIE, London,

Dr. DUFFIN, London,

MALCOLM MORRIS, Esq., London,

Dr. COLCOTT FOX, London,

Dr. SANGSTER, London,

Dr. WALTER G. SMITH, Dublin.

to which were added :

Prof. KAPOSI, Vienna,

Dr. BULKLEY, New York,

Prof. OSCAR SIMON, Breslau,

Prof. HÄRDY, Paris.

Amongst many others who attended, we noticed Behrend, of Berlin ; Vidal, Hillairet, and Eugene Verrier, of Paris ; Unna, of Hamburg ; Hans Hebra, of Vienna ; Schimmer, of Buda Pesth ; Th. Veiel, of Cannstadt ; Dubois, of Brussels ; Sherwell, of Brooklyn ; C. Boeck, of Christiania ; Angelucci and H. Rasori, of Rome ; and Cafavy, Stowers, Startin, Gaskoin, and O'Connor, of London. The Council was unfortunately disappointed in not having the pleasure of the presence of McCall Anderson, Besniér, and Fournier as it was anticipated, and it was much regretted that more American dermatologists were not present.

The following address was delivered at the opening of the Dermatological Section, by ERASMUS WILSON, F.R.S., President of the Royal College of Surgeons ; President of the Section.

MY BRETHREN : The Council of the Dermatological Section of this great Medical Congress offers you a hearty welcome. We assemble to-day as a part of a great International body, for intercommunion of friendship, of information, and of thought ; and just as the Congress, taken as a whole, has for its main purpose to diminish pain and suffering, and to promote the health of the people, so we, in our department, have met to coöperate with a similar intention. The important object now stated we hope to arrive at, partly by means of the new ideas which you, our foreign brethren, are about to sow amongst us, and partly by a judicial re-investigation and exposition of the principles which

we, at present, adopt for the diagnosis and treatment of cutaneous disease.

The bias of the British medical mind is strongly in favor of those studies which lead directly to the cure of disease ; and whilst we recognize fully the advantages and necessity of pathological research in every variety, the conclusion which we seek most ardently to attain, is—the means of restoring our patients most certainly and most readily to a state of health.

As a groundwork of our operations in this respect, we aim at the regulation of the general functions of the economy—of those all important forces, the functions of digestion, of assimilation, and of nutrition : for experience daily proves to us, that when such regularity is obtained, many of the diseases which we are called upon to treat yield to the ordinary processes of nature, and return to a state of health without further delay. And this we regard as the true significance of constitutional treatment ; by means of which every known disease of the skin may be ameliorated, and in most instances cured. But whilst we thus place constitutional medicine on a pedestal, as deserving the highest consideration of the practitioner, we by no means disregard the value of topical medicine. We have to contend with local lesions and with local pain ; and for the relief of these we seek for remedies which shall be, at once, the most convenient and the most effectual. In one case, a purge will relieve the patient ; but the addition of a soothing local application will be requisite for his cure. In another case, a local application alone will accomplish a great deal ; but the addition of a constitutional remedy will assist and facilitate the cure. But before we can answer the question : What is the best constitutional, and what is the best local remedy ? we must have made up our minds as to the *cause* of the disease, and as to the precise *method* by which we shall attempt the removal of that cause. Our treatment must not be haphazard or simply routine, but must be directed according to a fixed intention. Under such circumstances, the treatment of the disease itself is of comparatively secondary importance. Let us remove the cause and the disease will be cured spontaneously. Our patient may be a sufferer from eczema ; but our patient at the same time is a victim to dyspepsia. In such a case it becomes our duty to effect the treatment of the dyspepsia first, and the chances are, that when the dyspepsia is alleviated, the eczema will be wellnigh cured.

In another case, the eczema may be associated with more or less irritability of the nervous system, without any leading dyspeptic symptoms ; and in this instance our remedies should be directed toward the soothing and quieting of the nerve centres and nerves ; and both constitutional and local treatment should be invested with a sedative character. If there were any suspicion of impurity of blood in the first instance, there can be none in the second ; the first may be regarded as, in some sort, a blood disease ; the second as a nerve disease. But in both the local

treatment would be essentially the same, the difference between them being a difference not of disease but of cause.

Now, what we should endeavor to establish in these cases is not only a principle of treatment, but also the material of treatment. In the neurotic case, arsenic will be found a most useful, and probably an essential remedy ; in the other, or assimilative case, arsenic would be utterly worthless.

If all cutaneous diseases depended on the presence of a poison in the blood, as in the instance of syphilis, the elimination of the poison would be the aim of our treatment in every case, and the results would be as satisfactory as we know them to be in syphilitic affections. But in other cutaneous diseases it becomes necessary to settle in our minds whether we have to deal with a disease taking its origin in disturbance of the digestive functions, or whether it be neurotic to a greater or less degree ; whilst it must likewise be admitted that in certain cases, particularly those of long duration, both causes are apt to prevail.

For therapeutical purposes all diseases of the skin might be assembled, if we except syphilis and diseases proceeding from local causes, under three heads, namely : diseases depending on disorder of digestion and assimilation ; diseases depending on disorder of innervation ; and diseases of nutrition. As an example of the first kind we might take eczema, with its multitudinous manifestations. As examples of the second we should have pruritus and prurigo ; and as examples of the third, papilloma and fibrosis. But we cannot fail to recognize the fact that, practically, there is a greater or less blending of the whole. The pruritus of eczema belongs to disordered innervation ; and aberration of nutrition may be accompanied with symptoms which appertain to both the others. Thus, in the lepra of Willan, the psoriasis of modern schools, we have a disease which is due to altered nutrition of the skin from defective organization of that structure. But as the nerve-power or life-power of the skin is insufficient to restrain abnormal function, so—capillary congestion constitutes a part of the disease ; and the hypertrophous growth of papillæ and excessive production of morbid epidermis must be regarded as a passive nutritive change or passive growth. In ichthyosis, with a starved condition of the skin as far as nutrition is concerned, we have an excessive papillary growth, an excessive accumulation in the shape of altered epidermis. But still more interesting illustrations of abnormal nutrition are evinced by excess or defect of pigment ; by the substitution of a lowly for a more highly organized tissue, as in fibrosis ; and by the exuberant proliferation of cell-tissue of low organization, which is met with in the instances of tinea, of favus, and of epithelioma.

If I were called upon to summarize the diseases of the skin such as they exist most commonly in this country, I should begin with eczema, as occurring at all ages and in every condition of life ; tinea might follow next as a disorder of childhood ; then the acne of youth ; and next, the so-called acne rosacea of the adult, which

latter is actually a form of eczema. The lepra of Willan is not very common ; neither is scrofula in its cutaneous forms. Looking to the cause of these diseases, we find mal-assimilation and nerve-irritability, aberration of nutrition and defective nutrition. And, therapeutically, our most reliable remedies are mild purgatives with tonics in the diseases of dyspeptic origin, nutritive tonics, and especially arsenic as a nutritive tonic, and in that sense a direct nerve-tonic.

What I have now said is intended to open up to the minds of my hearers a picture of the broad field in which we all mutually labor ; to point out that many portions of that field admit of independent exploration ; and to show that starting from the line of our existing knowledge there yet remains very much to investigate—singly, for the perfection of the parts ; and collectively, for the perfection of the whole. This is the field of Dermatological culture and research ; and with this brief introduction I now call you to the work of our section.

Once more, Brethren, we bid you welcome as friends and fellow-workers.

We now proceed to give a short account of the papers read and the ensuing discussions, for which we draw very largely on the excellent report that appeared in the *British Medical Journal* of London, and to describe the nature of the cases exhibited and that of the illustrations in the museum.

Dr. E. VIDAL, of Paris, read a paper on

Parasitic Pityriasis Circinata and Marginata and its Fungus, *Microsporon Anomæon* (*Microsporon Dispar*).

The paper was arranged under the following heads : 1. Description of *microsporon anomæon* ; 2. Lesions caused by it in the epidermis and at the orifices of the hair-follicles ; 3. Clinical characters of pityriasis circinata and marginata ; 4. Differential diagnosis from (a) pityriasis rosea of Gilbert and Bazin ; (b) erythrasma of Burchard and Bärensprung ; (c) tinea circinata ; 5. Prognosis and treatment.

Dr. ANGELUCCI, of Rome, discoursed

On the Etiology of Certain Scales in Diseases of the Skin.

The author said that, in the scales covering patches of psoriasis, in those of eczema papulosum, and in the horny septa between the lobules of molluscum contagiosum, spores were found imbedded in zoöglœa. The pathological changes in the skin caused by these spores in the above disease were analogous to the progressive necrosis of tissue described by Koch. In cultivation-liquids

these spores developed and became bacteria. Dr. Angelucci's observations led him to believe that although clinically distinct, the above diseases were caused by the same parasite.

Professor OSCAR SIMON (Breslau) had found the same bacteria in a great variety of skin diseases, and he stated that Klebs had shown them in variola. They were present also in healthy skin. The diagnosis of bacteria was difficult, as all epithelial cells which were exposed to the air, and which were cut off from nutrition, became degenerated and granular. In molluscum contagiosum the development went on in lobes from the deeper to the superficial parts.

Dr. UNNA (Hamburg) found that in molluscum contagiosum it was difficult to distinguish between eleidin-granules and bacteria in the rete Malpighii. In this disease the changes went on as in the healthy skin.

M. VIDAL (Paris) found that between the cells on the surface of the tumor there were many spores and bacteria; but he did not believe that they had any special relations to the disease. The same appearances were to be found in all sebaceous matter.

Professor KAPOSÍ (Vienna) believed that great care was necessary in drawing conclusions from such appearances, since Nägeli had confessed that he was unable to distinguish bacteria from granules of decaying protoplasm. Then, if organisms were really present, they might not be the cause of the disease.

Dr. THIN (London) had found in sections of molluscum contagiosum appearances similar to those described by Dr. Angelucci, but as the sections had not been made with a view to their demonstration, if present, and necessary precautions not taken, he had held his opinions in reserve. In preparations of skin affected with psoriasis he had not found the same appearances.

Dr. CAFAVY (London) suggested that inoculation experiments might be tried.

Professor OSCAR SIMON (Breslau) described an affection of the glans penis and inner surface of the prepuce, produced by a fungus, under the title

Balano-postho-mycosis.

There were at first slight irritation and erythema, then more intense inflammation and secretion. Then followed excoriations and painful sores, phimosis, and a condition eventually which resembled papilloma acuminatum. Occasionally there were growths of a callous character. All these growths were permeated by fungi. The cause of the disease was always diabetes mellitus. The fungus found a good nourishing fluid in the saccharine urine in the preputial sac. The decomposition of smegma was also to be taken into account. The fungus consisted of mycelium and spores. The latter were single, or in pairs, or in chains. The mycelium was thin and was forked, or sent off different branches. Sporangia or organs of fructifica-

tion were not observed. The prognosis was worse than in simple balanoposthitis. In treatment the disposition of diabetic patients to gangrene, etc., must be taken into account. Operations could not be done without having first treated the diabetes. Dr. Simon ordered drying powders with salicylic acid for frequent use. For operating on the phimosis and the growths he recommended the galvanic cautery.

Professor KAPOSI (Vienna) suggested the examination of the secretions of the prepuce in non-diabetic cases, so as to ascertain whether the fungus was found only in diabetic patients.

Dr. R. LIVEING remarked that persons who handled sugar were very liable to irritation of the skin. In diabetes irritation of the skin was more common in women than in men. He thought that sugar was the irritant.

Mr. MALCOLM MORRIS had observed a fungus in a case of simple balanitis, in which there was no diabetes.

Dr. UNNA (Hamburg) remarked that sugar in solution was favorable to the growth of fungi, but in powder it killed them.

The PRESIDENT asked whether the application of fuller's earth and oxide of zinc would not be sufficient to relieve the patient; and whether in this country habits of cleanliness did not account for the rarity of such cases.

Mr. BALMANNO SQUIRE remarked that cane-sugar was distinctly an irritant, but that glucose was not.

Professor O. SIMON, in reply, stated that in non-diabetic balanopostho-mycosis spirochæta and torulæ were found, but not the same mycelium that he had found in these cases. Moreover, in diabetic cases the mycelium penetrated more deeply.

Dr. ALFRED SANGSTER (London) read a paper on

A Papillary Tumor of the Scalp Presenting Peculiar Histological Characters.

This tumor was rather larger than a pigeon's egg, rising from the general surface about half an inch. The growth was papillary, and of a brownish tint, especially toward its margin. Many hairs devoid of pigment could be seen cropping up between the papillæ. The patient was quite healthy, and the tumor had existed from his earliest recollection. It had gradually increased in size. Microscopic examinations showed the deeper part to be mainly composed of dense fibrous tissue, while the more superficial portion was occupied by a new growth, probably sarcomatous.

Professor KAPOSI (Vienna) stated that he had described this disease under the name of *dermatitis papillomatosa capillitii*. Alibert had described it under the name of mycosis frambœsoides.

Dr. THIN considered the tumor of which Dr. Sangster submitted sections and drawings to be an epithelial growth. The new growth consisted of an epithelium similar to that which formed the new growth in rodent cancer.

M. HILLAIRET remarked that the tumor was not an example of a special disease. It began by inflammation, and was simply a papilloma produced by artificial irritation.

Professor KAPOSI added to his previous remarks that in this form of epithelioma there was always epidermic proliferation, but that it was not an epithelioma which destroyed. It was a dermatitis papillomatosa.

Mr. GASKOIN had seen a case which he believed to be of the same nature.

Mr. MORRANT BAKER also showed a living specimen with a scalp growth enclosing tufts of hair looking, certainly, very much like keloid, which was also regarded by Professor Kaposi as *dermatitis papillomatosa capillitii*.

Dr. H. RASORI, of Rome, described a

General Inflammation of the Sweat-Glands Following the Prolonged Internal Administration of Pilocarpin.

The paper contained a review of the writings on dermatology, for the last ten years, in reference to the subject of inflammation of the sweat-glands; a notice of the etiology of the disease, according to various authors; evidence that no partial or general inflammation of the sweat-glands due to pilocarpin had been hitherto noticed; and the history of the patient, course of the disease, treatment, and a description of the cutaneous sequelæ.

Professor SCHWIMMER (Buda Pesth) had seen one case of idrosadenitis after the injection of pilocarpin, but it was circumscribed, and only on the back.

Professor OSCAR SIMON (Breslau) did not think that Dr. Rasori had shown that the change was really a change of the sudoriparous glands more particularly.

Dr. UNNA (Hamburg) also doubted that it was true idrosadenitis.

Dr. RASORI had excised some of the papules, and had found in them débris of sweat-ducts.

Professor KAPOSI had often used pilocarpin, but had not seen a case in which these effects were produced.

Dr. UNNA, of Hamburg, read

A Critical and Historical Essay on the Sweat-Secretions.

Dr. Unna said that although the parts of the nervous system concerned in the production of sweat had been defined by recent physiological research, which had also shown the mutual independence of circulatory and sweat-phenomena, yet the old puzzle of "cold sweat" and "dry heat" was for each individual case still obscure. This failure on the part of a one-sided nerve-

theory had led the author to undertake a criticism of the opinions hitherto held as the basis of the ordinary theories of the secretion of sweat. It had not been shown, either by physiology or by pathology, that the sweat which exuded from the sweat-pores came exclusively from the sweat-coils, nor did such a conception harmonize with the facts of comparative anatomy. No one had hitherto contested the existence of an unbroken histological series of gradations between the ordinary sweat-glands and the glands surrounding the anus, the glands of the axilla, and the wax-glands of the ear; and that the latter continually, and the former intermittingly, poured out a secretion containing mucus, fat, or pigment. The watery element of the sweat, on the other hand, which no one had yet followed from the coil to the mouth of the duct, must, in part, be drawn from the blood-vessels of the papillary layer; perhaps, also, partly from those surrounding the duct, and from the *rete mucosum*, *there being free communication between the inter-epithelial spaces of the prickle-cell layer and the lumen of the duct*. The sweat was therefore a mixed fluid, derived from different sources, and its reaction varied according to its composition. Nerve-physiology had only shown that the secretion was independent of blood pressure, and of the rapidity of the circulation, but not of the circulation as a whole; and the theory which held that the sweat-coil secreted watery sweat under continual nerve-stimulus must be rejected. The best theory was that derived from a vaso-motor and a musculo-motor hypothesis, which explained the action of the involuntary muscles connected with the gland, the remarkable transitions between fatty, mucoid, and pigmented sweat, and especially the phenomena of "cold sweat." The "dry heat," on the other hand, observed chiefly in general febrile states, and in certain skin diseases, required other factors, outside the range of the nervous system, for its explanation. Amongst these, the expansion by heat of the horny layer of the epidermis specially deserved attention, as by this means the cleft-shaped lumen of the canal in the stratum lucidum was shut.

The President illustrated the peculiarities of the successive conditions of diminished and increased perspiration due to atmospheric influences, by relating his personal experience during the recent unusually hot weather in London.

Professor O. SIMON (Breslau) had made experiments on the influence of the nerves on the sebaceous secretion with positive results. Ludwig had had similar results in experiments on the duck. By carefully examining the skin in cases of seborrhœa, it could be seen that the moisture on the skin was partly due to the sebaceous secretion.

Dr. HEBRA (Vienna) said that the scalp was rich in sebaceous glands, and the palm in sweat-glands. Seborrhœa never occurred on the palms and soles, on which parts the secretion was always watery, with very little fat. The fatty matter found on the skin came chiefly from the sebaceous glands.

Dr. UNNA, in reply, said that nerves had not been demonstrated

for the sebaceous glands, but they had been demonstrated for the sweat-glands. On the nose the sweat-glands opened into the ducts of the sebaceous glands.

Dr. GUSTAV BEHREND, of Berlin, read an interesting paper

On Vaccinal Skin Eruptions.*

The author's position as public vaccinator had enabled him to pay considerable attention to this subject for several years. The paper contained reports of seven cases; of these, five (pustular, herpetic, and erythematous) appeared in the course of the first three days after vaccination, and one (resembling measles, but without fever and catarrh) on the eighth day. The seventh case was that of a rickety child, in whom preëxisting eczema was aggravated by vaccination. Further, the author was frequently informed by the mothers of children whom he had vaccinated, that evanescent erythema and urticaria had appeared in the first twenty-four hours, rapidly subsiding, so that they were no longer visible on the day of inspection (seventh day). The varied eruptions described were mild, and underwent spontaneous involution; they were not caused by any specific action of vaccine lymph, as precisely similar ones were noticed after the administration of certain drugs and articles of food.

Dr. HEBRA (Vienna) remarked that the prodromal eruption of small-pox could be diagnosed from its localization. It was always on the abdomen. It was certainly produced by variolous poison. He had seen one case of vaccine eruption after the eighth day.

Professor HARDY (Paris) remarked that vaccine eruptions were of three kinds: 1. Generalized vaccinia, which is common; 2. Exanthematic eruptions over the whole body, usually occurring before the development of the vaccine; 3. Diathetic eruptions, eczema; etc., often caused by vaccinia after the development of the vaccine pustule. Except in eczema, the prognosis was favorable. He referred, however, to one case of pustular gangrene. He himself had been revaccinated during the siege of Paris. Three days afterward he was attacked by severe general urticaria, followed by bronchitis.

Dr. BEHREND, in reply, remarked on the great rarity of vaccinia gangrænosa.

In connection with this paper we may mention that Mr. HUTCHINSON exhibited a portfolio of drawings of eruptions connected with vaccination, containing illustrations of unhealthy conditions in the vaccination sore, of the non-specific inflammatory eruptions following vaccination, including vaccinia gangrænosa, and of vaccination chancres and specific eruptions following them.

Dr. WILLIAM STOKES, of Dublin, showed a drawing of *gangrenous patches following vaccination*, though not of the primary sore.

* Printed in full in the ARCHIVES OF DERMATOLOGY, October, 1881, page 383.

Dr. ROBERT LIVEING (London) read a paper

On the Causes of Alopecia Areata.

He divided his paper into the following heads: 1. Parasitic hypothesis; 2. The disease considered as a neurosis; the latter hypothesis illustrated and confirmed by the following: *a.* Constitution of those liable to it; *b.* Various functional nerve-disturbances preceding and following the loss of hair; *c.* Action of blistering fluid on the skin affected; *d.* Regions especially liable to the disease; *e.* Changes in the skin and hair, the result of imperfect nutrition, and such as might probably result from defective innervation; *f.* Allied diseases.

M. VIDAL (Paris) remarked that there were several kinds of alopecia. There was first alopecia decalvans, which relapsed. He referred to a case in which the alopecia was limited to the nerve-zone of the great occipital and the auriculo-temporal nerves. Other cases followed moral shock, grief, etc. The local symptoms were pruritus and redness. This form was never contagious. In a second form (*Pelade achromateuse*) there was a tonsure. The skin became white and atrophied, forming a depression. This form resembled a parasitic affection, but was not parasitic. In the third form, regarded by Bazin as contagious, there were broken hairs as in ringworm, but the patch felt less hard to the touch. M. Vidal had seen contagion occur in this form in five members of one family; and again in three children of the same family; again in twins. He further alluded to a case in which one actor communicated the disease to another who wore the same wig. Referring to the alleged parasite, he remarked that no fungus was ever found deeper than the orifice of the sebaceous glands. He did not see his way to identifying any parasite as the cause of the disease. The changes were the same as in senile atrophy. The sebaceous glands atrophied and the secretion dried up.

Professor HARDY (Paris) considered that it was premature to decide whether there was more than one kind of area Celsi. He believed it probable that there was contagion in the first stage, but that it ceased to be active in the second stage. It was safe to isolate every case, as it was never certain that contagion might not occur. In illustration, he referred to a case in which a gentleman was infected on the scalp and in the beard by his groom after Cazenave had informed him that the malady was not contagious.

Dr. HEBRA (Vienna) had not seen instances of contagion in Vienna. He referred to a case in which the subject of alopecia areata died of pneumonia, and Jarisch found changes in the gray matter of the spinal cord.

Professor KAPOSÍ (Vienna) was opposed to the parasitic theory, and referred to the occasional difficulty of distinguishing between alopecia and tinea tonsurans. In many cases there were no nerve-symptoms or nervous antecedents.

Dr. UNNA (Hamburg) related the case of a girl, aged 20, who, after a fright, had epilepsy, hemicrania, Graves' disease, and, lastly, alopecia universalis areata. In another case of alopecia, in a boy, after other remedies had failed, a growth of a little fine down followed the use of the electric brush.

Professor SCHWIMMER adhered to the nerve-theory. In two cases, after failure of stimulating applications, a little down appeared after electricity had been used.

Dr. THIN remarked that it was useless to hold seriously the nerve-origin of the disease unless the bald patches were observed to be distributed in the course of a nerve, or changes could be detected in nerve-elements. This had not been the case in alopecia areata. He did not see how, after cases that had been already published, and after cases that had been related by MM. Vidal and Hardy, the occasional contagiousness of the disease could be denied. But a disease that could be communicated must have a contagium. This contagium he found in a bacterium he had described as existing in the hair-roots and between the root and root-sheath. The remedy he had found most beneficial was sulphur ointment, well rubbed into the patches and their margins.

Professor OSCAR SIMON (Breslau) said that the nerve symptoms are very prominent in local cases.

Dr. ALLAN JAMIESON had found the disease always in dark-haired, never in red-haired, persons. He had found in one case morphœa associated with alopecia areata. Nervous symptoms predominated in these cases.

Mr. GASKOIN had seen instances of contagion.

In connection with this subject an interesting case was shown by Dr. SANGSTER, in which the hair turned white in tufts before falling.

Dr. EUGÈNE VERRIER (Paris) read a long paper

On the Influence of Climate, Difference of Race, and Mode of Life, in the Development and Character of Parasitic Diseases of the Hairy Scalp.

After a summary of the various parasites of the skin, and especially of the hairy scalp (fungi of the different tineæ), the author reviewed the influence of the climates of France and the French colonies on the diseases resulting from the development of these fungi, and pointed out the importance of establishing a medical geography. He then examined, separately, the various races who inhabited the French colonies, and a few others, and showed the influence exercised by these races on the propagation of parasitic diseases of the hairy scalp. Lastly, the mode of life of the populations of all French countries, and of some parts of Europe, was examined in reference to this question.

Dr. ERNST SCHWIMMER, of Buda Pesth, read a paper on

Leucoplakia Buccalis,

a name given to an idiopathic affection of the mucous membrane of the mouth and tongue, to distinguish it from symptomatic alterations occurring in the course of other diseases, especially syphilis. The names ichthyosis, tylosis, keratosis, and psoriasis membranæ mucosæ, by which it had hitherto been known, did not sufficiently emphasize the distinction between idiopathic and symptomatic forms, frequent errors occurring in diagnosis and treatment. The characteristic changes of the idiopathic affection consisted of red circumscribed hyperæmic patches on the tongue and inner surfaces of the lips and cheeks. These might last for some weeks or months, and then either subside, or become developed into circumscribed grayish or white discolorations. The same changes occurred in syphilis of the mucous membranes, but the affection of the epithelium came on with much greater rapidity. Further, in syphilis, either as a result of treatment or spontaneously, the affection subsided with ease; in the idiopathic affection, on the contrary, the diseased epithelium gradually became thicker, and extended into the deeper tissues, giving a thickened and fissured aspect to the patches. The whole process was characterized by infiltration and cell-proliferation of the corium, which explained the obstinate persistence of the patches, and the readiness with which they underwent conversion into other processes. Disease of the digestive tract, and excessive smoking, especially of strong tobacco, were of importance in the production of this affection, and syphilis itself might be a predisposing cause. This made the diagnosis difficult; but specific treatment, under which the idiopathic affection continued unmitigated, would serve to distinguish them. The avoidance of every thing calculated to irritate the diseased mucous membrane was of primary importance, as serving to prevent an extension of the process. Cleanliness, and the frequent washing of the mouth, especially with alkaline washes, were of great benefit. Irritative treatment was usually unfavorable, Dr. Schwimmer had occasionally seen a temporary alleviation by solution of silver nitrate, but never a permanent cure. The most favorable local treatment was the application of a half-per-cent. solution of corrosive sublimate, or one per cent. chromic acid, under which a considerable number of cases had been permanently improved, and the passage into carcinoma possibly prevented.

M. HILLAIRET agreed with Professor Schwimmer that the affection was not psoriasis, and that the term psoriasis of the tongue ought to be abandoned. The etiology was very obscure. Amongst the cases he had seen, many had occurred in persons with syphilitic taint and in smokers. It began by extreme sensibility, after which patches appeared, and these were often the first changes of cancrioid. It was curable in old syphilitic patients. It occurred also in non-smokers. The irritation set up by false teeth might

give rise to it, but the cause was often not recognizable. He had had good results from chromic acid and the frequent use of alkaline washes. In syphilitic patients it disappeared under iodide of potassium.

Professor KAPOSI (Vienna) said that a great distinction should be drawn between the earlier and the later stages. The latter he had named *keratosis mucosæ oris*. It occurred chiefly in syphilitic persons; but the later stages were not influenced by anti-syphilitic treatment. It might pass into cancer by continued irritation. Cases occasionally occurred in hysterical women and nervous persons. In such cases there was hyperæsthesia of the tongue, which was denuded of epithelium, and had hypertrophied papillæ. It was impossible to diagnose the syphilitic from the non-syphilitic cases.

M. VIDAL (Paris) remarked that psoriasis was a bad name, and that the diagnosis from a late manifestation of syphilis was extremely difficult.

Mr. MORRANT BAKER said that Mr. Hulke had long ago described the affection. It was non-syphilitic; not one case in ten being due to syphilis.

Mr. CLEMENT LUCAS believed that the disease had no relation to ichthyosis or psoriasis, and doubted that syphilitic could be distinguished from non-syphilitic cases. He related the history of a case in which leucoplakia developed thirty years after the infection of syphilis, and eventually became epithelioma.

Dr. BEHREND also concurred in the opinion that it was not always due to syphilis.

Dr. BULKLEY said that the affection was a very common one in America, and cases had been repeatedly exhibited before the New York Dermatological Society, by this same name *leucoplakia*, and he had always supposed that the name emanated from one of the members of the Society; it appeared in "The Transactions," in the ARCHIVES OF DERMATOLOGY, several years ago. He believed tobacco, especially smoking, was a very important factor.

The President had often seen epithelioma begin in leucoplakia.

This affection, variously named ichthyosis, psoriasis, and tylosis linguæ, was illustrated in the museum by drawings lent by Mr. Davies Colley, Dr. Godhart, and others.

MM. VIDAL and HILLAIRET (Paris) were allowed to introduce into the programme a paper consisting of a sketch of the pathological anatomy and clinical history of a disease of the skin which, they thought, had not been widely recognized out of France, namely,

Lymphadenoma.

Alibert first used the term mycosis. Hardy called it hypertrophic lichen. In a case which was examined by Ranvier the disease was found to be lymphadenoma. The tumors were some-

times as large as tomatoes, or they might be as small as a pea. They produced no irritation. There was first hyperæmia, which went on to ulceration, the neighboring lymphatic glands becoming hard. Sometimes tumors appeared and disappeared in a day or two spontaneously; but they relapsed again and again. They might appear in the mouth and tonsils, and hemorrhages might take place in the brain and other organs. Histologically, the tumor was lymphadenoma; clinically, it was different. The tumors reappeared more actively. The white corpuscles in the blood were increased only in the very latest, the cachectic stages.

Professor KAPOSI (Vienna) said that these cases were the same as those described by Dr. Duhring as *sarcoma cutis multiplex*.

Professor O. SIMON (Breslau) thought that the disease was started by some superficial irritation in the first instance. He recommended treatment by pyrogallic acid.

The President had called the disease *eczema tuberculatum*, and considered the tumors to be adenoid.

Dr. WALTER G. SMITH (Dublin) described one of those curious cases of

Dipterous Larvæ Beneath the Human Skin,

of which there are now a number on record.

A girl, aged 12, presented herself with the following history: About three months before being seen by a medical man, an ovoid swelling appeared on the outer side of the right ankle, causing her some pain and uneasiness in walking. This swelling gradually shifted its position, and slowly moved up the leg, thence toward the right axilla, then down to the elbow, and finally settled on the back of the neck. In this situation a small dark spot appeared, an orifice formed, and when pressure was made around this opening, a white grub, nearly an inch in length, protruded and escaped along with some unhealthy pus. Several other similar swellings developed upon subsequent occasions under medical observation, and the medical man extracted other grubs, exactly similar to the first specimen. No cause could be assigned for these curious phenomena. The larvæ were pronounced by competent authority to belong to a dipterous insect, although the genus could not be satisfactorily determined. There was no sufficient proof of the existence of an *œstrus* peculiar to man alone.

Dr. THIN (London) described a case of

Congenital Abnormality in the Production of Hair on the Scalp,

in a girl, aged four, whose hair, although normal in quantity, was defective in its formation, and was reported to have been so since infancy. The hairs were rough and crisp to the touch, varied in

length from a fraction of an inch to little over an inch in length, and broke off in numbers when the scalp was firmly rubbed. There was continual formation and continual breaking of the hairs. When the hand was passed over the head of the child, the sensation experienced was like that felt on rubbing a pig's skin against the direction of the hairs.

Professor KAPOSÍ (Vienna) had seen two cases of the same kind. In one, a boy four years old, there were present features of lichen pilaris, especially on the neck. The affection was congenital, like ichthyosis. The second case was exactly similar. There was a gradual improvement in the first case under stimulating local treatment.

M. VIDAL (Paris) had also seen similar cases, but twice only. The sebaceous system was poorly developed in them, and the affection was probably due to defective development of the sebaceous glands. Breaking of the hairs was also found in seborrhœa sicca.

Dr. UNNA (Hamburg) had under his care a case of the same affection in a young lady. It was in this instance limited to the vertex, having come on after great mental depression. As in alopecia, there was dryness of the skin and coarseness of the hair, with hardness of the scalp. He thought it like scleroderma circumscripta. It got better under sulphur ointment.

Dr. R. LIVEING had seen one similar case, which had existed from earliest infancy.

Dr. BULKLEY (New York) had seen one case, in a boy aged 6, in whom there was also marked lichen pilaris on the arms.

The President remarked on the various alterations of the hair, and referred to its occasional wiry condition.

The President read a short paper on

Dermato Therapœia.

He explained what he termed the sealing process, in which the skin was kept completely protected by repeated applications of benzoated zinc ointment, the use of water being avoided. This ointment did not suit for the scalp, where an ointment of one part of red oxide of mercury ointment diluted with three parts of unguentum petrolei gave excellent results. A lotion of oxide of zinc, calamine, and lime water left a deposit on the skin, which was also an excellent protective.

Dr. SANGSTER related

A Case of Supposed "Neurotic Excoriation,"

which had been under observation at intervals for three years. It was one in which painful erythematous patches were succeeded by exudation, on the surface, of serum and sero-pus, each patch

terminating in desquamation, and running its course in ten to fourteen days. There was no vesiculation or loss of substance. The longest interval during which the patient had been free from the lesions was three months. When the case first came under notice, it was described by the author in the Clinical Society's *Transactions* as one of abortive herpes; but its subsequent history went to show that the eruption (if genuine) was probably one of "neurotic excoriation" (Wilson). The patient had been under close observation in Charing Cross Hospital on two occasions; and had been seen by many gentlemen in London especially interested in diseases of the skin.

The President remarked that the case did not correspond to those described by him as instances of "neurotic excoriation." By this term he had designated a special affection of the cutaneous nerves, with pruritus, leading to hyperæmia and transudation, and sometimes to hemorrhage. But when there were pruritus, hemorrhage, and transudation, one factor only might predominate. He related a case of a young lady, in which blood-crusts were found on the face, although the patient was unaware of their presence. The patches were often symmetrical. He referred to another case in which, on taking off a glove, the hand was found bleeding. In these cases the shape of the patches was crescentic, advancing by a convex border. The cases were always attended by prurigo.

Dr. LIVEING, during a long period of observation of Dr. Sangster's case, had seen a great variety of eruption in it, and was therefore induced to believe that the patches were artificially produced. In this patient the skin was probably unusually sensitive. Two years ago the appearances resembled very closely those considered by the President as characteristic of his neurotic excoriations. He referred to a case recently seen, in which hemorrhage was so easily produced, that blood could be drawn through the walls of the vessels by suction.

Dr. UNNA (Hamburg) said that the patch which he saw on the thigh of Dr. Sangster's patient impressed him as being artificially produced. It had sharp edges, and was straight and oblong in form.

Professor O. SIMON (Breslau) said that Appenbrodt had described a very similar case as an instance of vaso-motor neurosis. In that case it was certain that the eruption was not produced by artificial means.

Dr. THIN was certain that in Dr. Sangster's case, if the girl's hands were tied behind her back, there would be an end of the eruption. He had seen the case some months previously, and had examined an oblong erythematous patch on the front of the thigh, traversed from end to end by four linear excoriations, evidently produced by the four finger-nails.

Mr. STARTIN had observed a similar case in a little child in which the eruption seemed to follow the course of the superficial nerves of the abdomen and front of the thigh.

Mr. MORRANT BAKER remarked that the quadrilateral shape of the patches pointed to their artificial production.

Dr. BULKLEY had reported a case in the ARCHIVES OF DERMATOLOGY, July, 1880, where lesions which had been supposed to be neurotic were found to be produced artificially for the purpose of deception.

Mr. GASKOIN had seen linear and quadrilateral forms of erythema, and did not think that they were artificial.

The President remarked that there was agreement that in these cases there was a peculiar and specially irritable condition of the skin.

Dr. SANGSTER, in reply, said that he was glad to be able to claim the President's support in regard to the genuine nature of the eruption. The case was probably a mixed one, mechanical irritation producing effects which probably would not follow on a healthy skin. The patient had often been watched without fraud being detected. Professor Kaposi had suggested that it might be a bullous urticaria with abortive bullæ. Still, it was remarkable that the patient had never had any lesions on the face.

(We understand that Dr. Sangster has since satisfied himself that the lesions are produced purposely by the girl by forcible tearing with the nails.)

Dr. STOWERS (London) related the case of a female patient, aged 47, whom he exhibited, suffering from

Scleroderma Diffusa (Sclérème des Adultes, Thirial).

The case illustrated the advanced form of the above disease, the pathological changes having been first noticed at the age of 23, and affecting the skin, subcutaneous tissue, and bones. The regions involved included the scalp, ears, face, neck, trunk, and extremities. The case was characterized by discoloration and structural changes of skin, fixedness of joints, shortening of bones, disordered and impaired sensation, and pain. The paper included observations on the nature and cause, clinical history, and structural alterations of scleroderma.

Mr. GASKOIN also showed another well-marked case, and Dr. Colcott Fox a third of the same disease, which had been under observation for some years and was now almost recovered.

Lupus was largely illustrated to the section, in almost all its forms. Thus, cases were shown by Morrants Baker, Malcolm Morris, Stephen Mackenzie, and Startin. One of Morris' cases showed the very early condition of lupus erythematosus described formerly by Hebra as *Seborrhœa congestiva*, whilst a second was of very extensive distribution on the body and was of interest as illustrative of the difficulty in diagnosing between lupus vulgaris and lupus erythematosus in some cases. Further, in the museum

the disease was plentifully illustrated in all its forms by Guy's Hospital models, Mr. Hutchinson's collection of beautiful drawings, and in the section itself by Professor Kaposi's portraits brought over to illustrate the subject. Moreover, Mr. Hutchinson gave a demonstration from drawings on lupus as it attacks mucous membranes.

A most interesting discussion was afterward opened in the section by

Prof. KAPOSI, who read a careful paper on

Lupus Erythematosus.

He thought that the question should be : Is lupus erythematosus an inflammatory process or a neoplasm? He gave a description of the clinical symptoms and the histological characters of the process, and believed that its inflammatory character might be proved by them. He insisted at the same time on its being quite different from lupus vulgaris. To further penetrate into the nature of the process, he put another question : What kind of inflammation is it which so rapidly leads to a cicatrization of the skin? He divided that question into two parts : (a) What is going on locally? (b) What remote causes may lie at the bottom? The first was answered by the results of histological examination, which he explained in its essential points. In trying to give an answer to the second one, he was led to discuss the etiology of the disease, and to give his own opinions, which were to the effect that the disease undoubtedly began and lasted as a local process ; that, in the form described by him as lupus erythematosus acutus, the whole organism was attacked, but that not even in these cases was it necessary to suppose the primary cause of the process to be in the nervous centre, or in a special faulty constitution. Before closing the pathology of lupus erythematosus, he submitted another question : If his division of lupus erythematosus into two forms, as lupus erythematosus discoides, and aggregatus, might not be found as corresponding best to the clinical features? He then proceeded to discuss the various methods of treatment proposed in this disease.

Dr. THEODOR VEIEL (Canstadt) had arrived at the following conclusions : 1. Lupus erythematosus is an independent disease, and not a variety of lupus vulgaris ; 2. No connection between it and scrofula, tubercle, and syphilis, can be shown ; 3. The affection of the sebaceous and sweat-glands is only an accidental accompaniment of the disease, the essential feature of which is the change which advances along the blood-vessels ; 4. There is no remedy given internally which will cure the disease ; 5. The most effectual treatment of the disease is multiple scarification, and subsequent cauterization by chloride of zinc.

The President remarked that the affection was inflammatory. It arose after exposure to irritating influences, beginning as an

erythema which became permanent. He referred to the case of a woman in whom, during pregnancy, erythema appeared on the face. After exposure to the cold, the erythema spread over the trunk, and eventually became lupus erythematosus.

M. VIDAL (Paris) thought that lupus erythematosus was not inflammatory, but occupied an intermediate position between inflammation and neoplasm. It was cured by producing inflammation. He recommended scarification, and then, to obtain inflammation, Vigo's plaster.

Dr. UNNA (Hamburg) remarked that, clinically, it was usually possible to distinguish between inflammation and new growth, but in lupus erythematosus the line could not be drawn. The disease was first inflammatory, and then a new growth.

Professor SCHWIMMER believed that it was a purely local disease, and inflammatory.

Dr. THIN said it was only recently that the distinction between lupus erythematosus and lupus vulgaris had been widely recognized in this country. Some years ago, when discussing the pathology of lupus erythematosus at one of the medical societies, he had found himself called on to defend the distinction that he had drawn between them.

Prurigo is a disease on which much light was thrown at the congress, for, though apparently well known in Germany since Hebra's description, and recognized more rarely in France by Bazin, Hillairet, and others, in America it is only known as a *very rare* affection, and the same is true in England. Moreover in the latter country at any rate, great confusion has existed as to what should be really included under the term *prurigo*, and this has hardly been cleared up by Mr. Hutchinson's writings on the subject. Mr. Marrant Baker, therefore, deserves thanks for exhibiting three cases which were acknowledged as undoubted *prurigo* by Prof. Kaposi, Dr. Hans Hebra, and other German observers. These cases formed the prelude to a paper by Mr. BAKER on

Prurigo or Eczematous Prurigo, or Pruriginous Eczema.

The author drew attention to the frequent occurrence in England of a disease usually confounded with eczema, to which it bore, at first sight, a striking resemblance, but which had typical characters of its own, and was essentially *prurigo*. He thought the chief cause of the disease being so frequently overlooked was to be found in the fact that the symptoms of *prurigo* were masked by the eczema, which, in children especially, was always present to a greater or less degree, and often in a most severe form. The author believed that the supposed rarity of true *prurigo* in England, at least in children, was due rather to the cases being overlooked than to their not occurring.

Dr. LIVEING had published cases of true *prurigo* observed in

England six years ago. Lichen urticatus was often the starting-point of true prurigo.

Mr. MALCOLM MORRIS had found the disease totally disappear before a certain age, and never found it after the age of twenty-one.

Professor KAPOSÍ said that Mr. Baker's cases, which had been shown at the previous meeting of the section, were certainly examples of true prurigo. In the diagnosis, the whole disease must be taken into account. The localization was chiefly on the extremities, mostly on the lower, beginning in infancy, and always with symptoms of urticaria. Papules appeared later on the back and buttocks and buter surface of the extremities. The disease was developed about the second year of life. There was great difference between prurigo mitis and prurigo agria. Lichen urticatus was an acute disease, which disappeared in a fortnight or three weeks; but it might relapse, and it would not lead to thickening, infiltration, dryness, and pigmentation of skin. Prurigo mitis, if treated early, was curable in a few years.

Dr. HEBRA (Vienna) said that prurigo had been first described by Willan. It had been overlooked in England through being confounded with eczema, which was only one character of the whole disease, just as in scabies eczema was also only one symptom. The localization was very important. The essence of prurigo was the internal unknown cause of the itching, which gave rise ultimately to the lesion called prurigo. Auspitz put it amongst the neuroses of the skin, and with this Hebra fully agreed. The papules were only a later appearance. The treatment by sulphur baths, carried on for one or two years, was effective in the early cases.

Dr. WALTER SMITH (Dublin) found prurigo comparatively frequent in Ireland. He had seen true prurigo without eczema. It lasted many years, till, at the age of thirty, the patient nearly but not quite recovered. The only treatment found of use was pilocarpin or Turkish baths.

The President considered the cases shown by Mr. Morrant Baker, at the previous sitting of the section, to be cases of chronic eczema, and not prurigo. He believed these cases to be curable, and recommended the application of zinc ointment night and morning, three minims of liquor arsenicalis thrice daily, and good food.

Dr. SANGSTER remembered a case of ichthyosis which became eczematous, and had seen cases of xeroderma in which eczema was very easily produced, and was very chronic.

Dr. BULKLEY (New York) had seen not more than one or two cases in America exactly like the Vienna cases of prurigo. Only three cases had been recorded in the United States. Lichen urticatus was something different.

Dr. UNNA (Hamburg) agreed with Mr. Baker. The cases he had seen at Hamburg were milder than those he had seen at Vienna.

Professor O. SIMON (Breslau) said that there was a great deal of true prurigo, both in Berlin and Breslau—both prurigo agria and prurigo mitis. The cases he had seen in London were examples of the disease. Pilocarpin he had found useful, and many patients did not relapse after it.

Dr. ALLAN JAMIESON thought prurigo might appear for the first time in later life.

Professor KAPOSI replied that prurigo never began in later life.

Mr. MORRANT BAKER, in reply, said that lichen urticatus was easily curable, and doubted whether simple scratching and itching were enough to cause the disease. He had seen a case of prurigo without eczema, and a case in which what was very like prurigo appeared in later life.

Dr. BULKLEY (New York) presented in abstract a paper entitled

On the Nomenclature and Classification of Diseases of the Skin,*

with a view of obtaining the influence of the congress in regard to simplifying and unifying the subject. He urged the adoption of a nomenclature based solely on the Latin and Greek, and presented a scheme to those present, exhibiting these features, and basing the classification on that of Hebra. A resolution was offered, seconded by Dr. Stephen Mackenzie, that an International Committee should be formed to take the matter into consideration, and to report at the next International Medical Congress. This was passed unanimously, and the following committee appointed: England, Dr. Robert Liveing; Austria, Dr. Moriz Kaposi; France, Dr. Emile Vidal; Germany, Dr. Oscar Simon; America, Dr. L. Duncan Bulkley, Chairman.

Many of the diseases of the skin were very well illustrated during the sessions of the congress.

Urticaria pigmentosa was of especial interest to visitors from other countries, as nearly all the cases hitherto reported have been observed in England. Four cases were shown, viz.: two by Dr. Mackenzie, one by Dr. Cafavy, and one by Dr. Colcott Fox, who also brought drawings of sections of the skin from the eruption. Dr. Fox's case was further of interest, because it was the one originally shown to the Clinical Society in 1874, by Dr. Tilbury Fox, and figured in his atlas. The wheals *now* do not take on the nodular xanthelasma-like aspect they formerly did, but are much like the other cases described and figured. Dr. Liveing also brought forward the case of a *grown-up girl*, which was very apropos, in as much as the more or less transitory wheals which developed left a marked pigmentary deposit behind them.

* Printed in full in the ARCHIVES OF DERMATOLOGY, October, 1881, p. 366.

Xanthelasma also was illustrated by some remarkable cases, viz.: one of *xanthelasma planum palpebrarum*, by Dr. Crocker, in a man with diabetes; one, by Dr. Gaskoin, of a man with *xanthelasma papules* and tubercles in groups upon the backs of the hands, forearms, elbows, and knees; and one, by Mr. Startin, of an apparently healthy girl of five years, in whom symmetrical groups of tubercles had existed for two years in the gluteal cleft, the points of the elbows, and the popliteal spaces. It was stated that the sister of this girl had similar patches in the popliteal spaces, and the case corresponded very closely with one recorded in the *Lancet*, some time since, by Dr. Colcott Fox. In none of these cases was there hepatic disease apparent. In the museum the opportunity was afforded of viewing the beautiful drawings of *xanthelasma* associated with jaundice from the Guy's Hospital collection, and Mr. Hutchinson's portraits of *xanthelasma palpebrarum*.

Morphœa cases (*circumscribed scleroderma*?) were shown by Mr. Marrant Baker, Dr. Radcliffe Crocker, Dr. Colcott Fox, Mr. Gaskoin, and Dr. Stephen Mackenzie. In Dr. Fox's case of very widespread *morphœa nigra* the disease had been watched for several years, and the *patches* covered almost the entire surface of the body, but curiously not the face, as in the diffuse *scleroderma* cases. The living cases were well supplemented in the museum by Guy's Hospital models and Mr. Hutchinson's drawings, in several of which the distribution in relation to the nerve supply of the parts was further well shown, and notably its close correspondence in site with *herpes ophthalmicus*. In connection with this point we noticed the transverse distribution of the patches on the leg in the Guy's Hospital model of *linear atrophy*.

Leprosy.—Seven cases of this disease were shown, and in all it was contracted abroad in the haunts of leprosy. Three of Mr. Hutchinson's cases were of the tubercular variety, whilst the fourth illustrated, in the person of an elderly woman, the well-known fact of the ultimate dying-out of the disease if the subject only live long enough. Dr. Crocker's two boys of nine years of age were from the East and West Indies respectively. In one the leprosy appeared after an attack of ague in Essex six months after arrival in England; in the other the ulnar nerve had been stretched without effect on the paralysis and anæsthesia. Mr. Startin's case was complicated by syphilis. Leprosy was further illustrated in the museum by many portraits, photographs, and wax models from the collections of Dr. E. de Wahl of Dorpat, Dr. Anderson of Japan, Mr. Hutchinson, and Guy's Hospital. An interesting series of specimens were shown from the museum of the Royal College of Surgeons of Ireland, illustrating atrophy of the bones from interstitial absorption, the alteration in the nerves, and atrophy of the testes in leprosy.

Dr. ABRAHAM also exhibited under the microscope excellent

specimens showing (1) degeneration of the glandular epithelium of the testes by intertubular small-celled growth, (2) hypertrophy of the sebaceous glands in the neighborhood of a leprous papule (leproma), (3) the thickening of the walls of the sweat-glands, (4) the accumulation of the small-celled growth around the vessels in an anæsthetic macule with subsequent fibroid degeneration and obliteration of the glands, (5) the growth in nerves, (6) giant cells undergoing vacuolation and fatty degeneration, (7) the zoöglœa masses of Hansen and micro-organisms, and (8) the thickening and infiltration of the coats of an artery as it entered a nodule. Mr. Malcolm Morris also showed two good specimens.

The preparations of *ainhum* and *mycetoma* clearly exhibited these curious affections to many visitors from the continent who had not previously had an opportunity of seeing these diseases.

Leucoderma in its ordinary characters was seen in a case (a girl aged 16 years) brought by Mr. Hutchinson; Mr. Baker also showed a girl, aged ten years, in whom the coincidence of deposition of pigment and clearance of pigment was peculiarly evident. This feature is often noted with difficulty. Some other *defects of pigmentation* were also illustrated; *e. g.*, Mr. Hutchinson showed a girl aged eight years with white hair, whilst the eyebrows and lashes remained of a dark brown color, except a tuft on one eyelid. The whole skin was fairer than natural. This condition was preceded by pityriasis rubra three years before, after which came complete baldness. Dr. Crocker brought a woman with deep pigmentation left by the disappearing lichen planus papules, and the same physician with Mr. Morris and Dr. Mackenzie brought examples of *lichen planus*. Mr. Morris contributed a case of a *pigmented papilloma*, growing on a cicatrix, consequent on the removal of a pigmented nævus. Other living cases shown were by Mr. Morratt Baker an *elephantiasic condition of the arm and hand*, with ulceration of the latter, due to inflammation and blocking of the lymphatics; *elephantiasis scroti*; by Dr. Crocker, a case of *miliary papular syphilide*, in a woman aged forty-three years, closely simulating lichen scrofulosus, which disease Prof. Kaposi, by the by, said he had seen in adults; by Dr. Liveing, *epithelioma developing upon an old syphilitic lesion*; by Dr. Dyce Duckworth, a case of *keloid* of ten years' standing, developed on the site of the application of a blister, and undergoing involution; by Mr. Hutchinson, a *recurrent pruriginous* (pruritic?) *herpetic eruption* (pemphigus à petites bulles?), and a case of *congenital papillary mole* in a man of twenty, unilaterally distributed on the scrotum, penis, and inner part of the thigh in groups and patches, evidently in the course of nerves, and suggesting to the exhibitor the possibility of its being due to intra-uterine herpes. Mr. Hutchinson had drawings of other cases bearing on the distribution of moles in relation to nerves. Dr. Colcott Fox brought a woman, aged sixty-five, with well-marked chronic *eczema mammae* (Paget's

disease of the nipple ; Thin's malignant papillary dermatitis) and secondary scirrhus of the breast. In the museum were specimens and drawings of the same. Lastly, out of the museum collection, we may select as of especial interest the various forms of *vesiculating erythema multiforme* and herpes iris (so-called hydroa), the large number of drawings of *rodent ulcer*, all of the upper two thirds of the face, excepting one on the upper lip and one on the back (Hutchinson) ; and for comparison with them the numerous representations of *epithelioma* ; two drawings of what Mr. Hutchinson has lately described as *lupus lymphaticus* ; Mr. Hutchinson's collection of portraits of iodide and bromide of potassium eruptions ; and, finally, the examples of the termination of cutaneous inflammations in gangrene, *e. g.*, Mr. Hutchinson's varicella gangrenosa, vaccinia gangrenosa, herpes gangrenosa, and gangrene of a patch of bromide of potassium eruption, the two Guy's Hospital models labelled rupia escharotica, probably representing varicella gangrenosa and pemphigus gangrenosa respectively, Mr. Stokes' gangrenous patches following vaccination, and the Guy's Hospital model of idiopathic circumscribed gangrenous inflammation about the knee.

It only remains to add that at the termination of the meetings of the section devoted to diseases of the skin a cordial vote of thanks to the President was moved, and, supported by Dr. Hans Hebra, M. Vidal, and Prof. Kaposi, was carried unanimously.

CLASS	I.	Morbi cutis parasitici.	Parasitic Affections.
"	II.	Morbi glandularum cutis.	Glandular Affections.
"	III.	Neuroses.	Neurotic Affections.
"	IV.	Exsudationes.	Exudative or Inflammatory Affections.
"	V.	Hæmorrhagiæ.	Hæmorrhagic Affections.
"	VI.	Hypertrophix.	Hypertrophic Affections.
"	VII.	Atrophix.	Atrophic Affections.
"	VIII.	Neoplasmata.	New Formations.

1. *Tinea trichophytina* (or trichophytosis) (*parasite—Trichophyton tonsurans*).

{	<i>corporis</i> (or <i>tinea circinata</i>). <i>capitis</i> (or <i>tinea tonsurans</i>). <i>barbæ</i> (or <i>sycosis parasitica</i>). <i>cruris</i> (or <i>eczema marginatum</i>).
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2. *Tinea favosa* (or favus) (*parasite—Achorion Schænleinii*).
3. *Tinea versicolor* (or chromophytosis) (*parasite—Microsporon furfur*).

B. ANIMAL.

A. DISEASES OF THE SEBACEOUS GLANDS.	{	I. Due to faulty secretion or excretion of sebaceous matter.	{	1. Acne sebacea	{	oleosa cerea cornea	{	(or seborrhœa).
		2. Acne punctata		{		nigra (or comedo). albida (or milium).		
		3. Acne molluscum (or molluscum sebaceum).						
		II. Due to inflammation of sebaceous glands with surrounding tissue.		{		4. Acne simplex (or vulgaris). 5. Acne indurata. 6. Acne rosacea.		
B. DISEASES OF THE SWEAT- GLANDS.	{	I. As to quantity of secretion.	{		1. Hyperidrosis. 2. Anidrosis.			
		II. As to quality of secretion.			{	3. Bromidrosis. 4. Chromidrosis.		
		III. With retention of secretion.		{		5. Dysidrosis. 6. Sudamina.		

Class III. Neuroses. Neurotic Affections.

1. Zoster (herpes zoster or zona).
2. Pruritus.
3. Dermatalgia.
4. Hyperæsthesia cutis.
5. Anæsthesia cutis.
6. Dystrophia cutis (or trophic disturbances).

Class IV. Exsudationes. Exudative or Inflammatory Affections.

A. INDUCED BY INFECTION OR CONTAGION.

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|--|---|---|
| | | <ol style="list-style-type: none"> 1. Rubeola (or measles). 2. Rötheln (or German measles). 3. Scarlatina. 4. Variola. 5. Varicella. 6. Vaccinia. 7. Syphilis. 8. Pustula maligna. 9. Equinia (or glanders). 10. Diphtheritis cutis. 11. Erysipelas. |
| | I. Erythematous. | <ol style="list-style-type: none"> 1. Roseola. 2. Erythema. 3. Urticaria. |
| | II. Papular. | <ol style="list-style-type: none"> 4. Lichen. 5. Prurigo. |
| | III. Vesicular. | <ol style="list-style-type: none"> 6. Herpes. 7. Hydroa. |
| | IV. Bullous. | <ol style="list-style-type: none"> 8. Pemphigus. 9. Pompholix. |
| | V. Pustular. | <ol style="list-style-type: none"> 10. Sycosis (or folliculitis pilorum). 11. Impetigo. 12. Impetigo contagiosa. 13. Ecthyma. |
| | VI. Multiform, <i>i. e.</i> ,
erythematous,
papular, ves-
icular, pustular, etc. | <ol style="list-style-type: none"> 14. Eczema. 15. Dermatitis. |
| | VII. Squamous. | <ol style="list-style-type: none"> 16. Dermatitis exfoliativa (or pityriasis rubra). 17. Psoriasis. 18. Pityriasis capitis. |
| | VIII. Phlegmonous. | <ol style="list-style-type: none"> 19. Furunculus (furunculosis). 20. Anthrax. |
| | IX. Ulcerative. | <ol style="list-style-type: none"> 21. Onychia. 22. Ulcus. |

B. OF INTERNAL OR LOCAL ORIGIN.

{ simplex.
multiforme.
nodosum.

{ simplex.
planus.
ruber.
scrofulosus.

{ febrilis.
iris.
progenitalis.
gestationis.

{ vulgaris.
foliaceus.

(or cheiro-pompholix).

{ calorica.
venenata.
traumatica.
medicamentosa.

{ simplex.
venereum.

Class V. Hæmorrhagiæ. Hæmorrhagic Affections.

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| 1. Purpura | { simplex.
papulosa.
rheumatica (or peliosis rheumatica).
hæmorrhagica. |
| 2. Hæmatidrosis | (or bloody sweat). |
| 3. Scorbutus. | |

Class VI. Hypertrophie. Hypertrophic Affections.

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|------------------------------|--|--|
| A. OF PIGMENT. | { 1. Lentigo.
2. Chloasma.
3. Melanoderma. | 4. Nævus pigmentosus.
5. Morbus Addisonii. |
| B. OF EPIDERMIS AND PAPILLÆ. | { 1. Keratosis pilaris (or lichen pilaris).
2. Ichthyosis.
3. Cornu cutaneum.
4. Clavus.
5. Tylosis (or callositas). | 6. Verruca { vulgaris.
senilis.
acuminata.
necrogenica |
| C. OF CONNECTIVE TISSUE. | { 1. Scleroderma.
2. Sclerema neonatorum.
3. Morphœa. | 4. Elephantiasis (Arabum).
5. Dermatolysis.
6. Framboesia (or yaws). |
| D. OF HAIR. | 1. Hirsuties. | 2. Nævus pilosus. |
| E. OF NAIL. | 1. Onychogryphosis. | 2. Onychauxis. |

Class VII. Atrophie. Atrophic Affections.

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|----------------|---|
| A. OF PIGMENT. | { 1. Albinismus.
2. Leucoderma (or vitiligo).
3. Canities. |
| B. OF CORIUM. | { 1. Atrophia cutis { propria.
linearis (or striæ atrophicæ).
maculosa (or maculæ atrophicæ).
2. Atrophia senilis. |
| C. OF HAIR. | { 1. Alopecia.
2. Alopecia areata.
3. Trichorexis nodosa (atrophia pilorum propria, or fragilitas crinium). |
| D. OF NAIL. | Onychatrophia. |

Class VIII. Neoplasmata. New Formations.**I. BENIGN NEW FORMATIONS.**

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|---------------------------|---|
| A. OF CONNECTIVE TISSUE. | { 1. Keloid.
2. Fibroma (or molluscum fibrosum).
3. Xanthoma (xanthelasma or vitiligoidea). |
| B. OF GRANULATION TISSUE. | { 1. Lupus { vulgaris.
erythematosus.
2. Scrofuloderma.
3. Rhinoscleroma. |
| C. OF BLOOD-VESSELS. | { 1. Nævus vasculosus.
2. Angioma (or telangiectasis). |
| D. OF LYMPHATICS. | { 1. Lymphadenoma cutis.
2. Lymphangioma cutis. |
| E. OF NERVES. | Neuroma cutis. |

II. MALIGNANT NEW FORMATIONS.

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|--------------|--|
| 1. Lepra | { tuberosa }
{ maculosa } (leprosy, or elephantiasis Græcorum). |
| 2. Carcinoma | { epitheliomatousum (epithelioma and rodent ulcer).
papillomatousum (or papilloma).
{ idiopathicum.
pigmentosum (or melanosis). |
| 3. Sarcoma | |

I.

DISEASES OF THE SKIN.

GENERAL TOPICS AND THERAPEUTICS.

T. COLCOTT FOX, B.A., CANTAB., M.B., LOND.

Dartre.—The article *dartre* (running to forty-seven pages) in the elaborate medical encyclopedia now appearing in Paris, is of interest as one of the last of BAZIN's writings. The word *dartre* is generally derived from *δαρτος* (from the excoriations induced), but Littré thinks it comes from the Sanskrit word *derdru*, through the Celtic language. Bazin first shows that the word *dartre* came into scientific use at the Renaissance, and was used synonymously with the word *herpes* until Alibert's time, to designate a group of affections dissimilar in external form but identical in nature or causation. Willan and Bateman demolished this class of disease, but Alibert, who wrote the article *dartre* in the *Dict. des Scien. Méd.*, in sixty volumes, re-erected it to denote an itching, chronic, inflammatory group of affections characterized by papules, vesicles, or pustules, terminating in scales or crusts, surrounded by red areolæ, grouped or in boquets, and often leaving indelible cicatrices. Later on Hardy, by *dartre*, designates not a disease but a class, characterized on the skin by non-contagious eruptions with diverse elementary lesions, tending to spread, chronic, usually itching, disappearing without leaving cicatrices, often hereditary, and inclined to recur. Bazin then goes on to give the views held by himself, and discusses whether there is such a diathesis or constitutional disease, distinguishing between the two, and concludes that *herpetism* is a constitutional vice or special predisposition, not to be confounded with heredity, non-contagious, non-inoculable, manifesting itself variously in the skin (*herpétides*), mucous membranes (some forms of angina and bronchitis), nerves (migraines and neuralgias), and viscera (dyspepsia, dry asthma). The *herpétides*, which are characterized by gradual extension, chronicity, excessive abundance of epidermic proliferation and the good influence over them of arsenic, are easily distinguished from syphilides and scrofulides, and from the arthritides with which they have so many close resemblances, by the absence of articular manifestations, and by their chronicity, gradual extension, and the indefinite character of the cutaneous affections. The points of difference are gone into in detail, enabling him to distinguish, for instance, the herpetic forms of urticaria, eczema, and pemphigus from the arthritic varieties. Bazin then asks the pertinent question whether the word *dartre* ought to be preserved in science, and holding that it has been useless for diagnostic purposes, and has not helped us to the real nature of the affections included under it from time to

time he concludes that the word is useless and a clog to the progress of dermatology, "nous disons simplement que nous proposons de rayer le mot 'dartre' du vocabulaire dermatologique, parce que c'est un mot qui s'applique à tout et ne s'applique à rien."—*Dict. Encycl. de Sci. Méd.*, Paris, 1880, 1 s, xxv, p. 647.

Clinical notes on eruptions occurring in the febris intermittens of West Africa.—Urticaria has several times been described as occurring during the course of febris intermittens, and ALLAN now records the occurrence in one case, during the hot stage, of a well-marked erythematous eruption, which has also been noticed before, and of a hitherto undescribed papular eruption of a variolous type.—*Dublin Med. Journ. Sci.*, 1881, 3 s, lxxi, p. 89.

Kandahar sores.—J. FLEMING observed "sores," resembling the well-known Delhi sore or boil, Mooltan sore, etc., for which the term Oriental sore was proposed, occurring in soldiers in Cabul, who had been sometime stationed at Kandahar. He recommends the application of strong nitric acid in all stages, and refers to the Army Medical Reports for 1869, vol. xi, p. 511.—*Brit. Med. Journ.*, 1881, 1, p. 805.

An improved diachylon ointment.—DUHRING has an important little note on the preparation of Hebra's diachylon ointment, which can only be compounded satisfactorily when the greatest care is devoted to it, and then only by those with some special experience in the matter. Pharmacists note too that it doesn't keep well. Mr. Eisner, a pharmacist of Philadelphia, recommends the following materials and method: Let one part of freshly precipitated (from acetate of lead), pure white hydro-oxide of lead be rubbed down with two parts of water, and be well mixed with six parts of the best Lucca olive oil. Stir the mixture for about two hours over a hot-water bath near to boiling point, and then cool with constant stirring until the proper consistence is obtained, and whilst the mass is cooling add one drachm of oil of lavender to each half pound of ointment. This makes a smooth, whitish, elegant ointment of neutral reaction, and contains, according to Eisner, oleo-stearate of lead. Moreover, it keeps well, and contains a definite amount of oxide of lead, whereas in the old ointment the amount of litharge varies.—*Phila. Med. Times*, 1880-1, xi, p. 494.

Therapeutical properties of resorcin.—Resorcin is a new substance, chemically allied to phenol, and having many of the latter's properties, which is likely to come into use as a parasiticide and otherwise. Indeed DUJARDIN-BEAUMETZ has already used it locally with good effect in indolent ulcerations. ANDEER has shown its powerful antiseptic properties, and says that in a pure state in a one-per-cent. solution it arrests development of all the putrefactive fungi. Its colorless crystals are easily soluble in

water and in animal fats and oils. In the crystalline form it acts as a caustic of about the same strength as nitrate of silver.—*Fourn. de Méd. et de Chir.*, March, 1881; *Centralblatt f. Med. Wissen.*, 1881.

RECENT LITERATURE.

MEDICINAL RASHES.

HAMPELU. Ueber ein Arznei Exanthem. *St. Petersb. Med. Wochenschr.*, 1881, vi, p. 21. (Index Medicus, 1881, No. 3, p. 123.)

THERAPEUTICS.

ANDERS, T. O działaniu kwasu pyrogallusowego w niektórych cierpieniach skóry a w szczególności w łuszczycy. [Pyrogallic acid in squamous disease of the skin.] *Pam. Towarz. Lek.*, Warszawa, 1881, lxxvii, p. 177. (Index Medicus, 1881, No. 4, p. 181.)

BROWN-SÉQUARD. Effets inhibitoires de l'application du chloroforme et du chloral sur la peau et les muqueses. *Progrès Méd.*, Paris, 1881, ix, p. 43.

BUSQUET, J. B. A. Des avantages du traitement par occlusion dans les dermatoses démontrés par les enseignements de la physiologie et de la clinique. *Thèse de Bordeaux*, No. 4, 1880. (Index Medicus, 1881, No. 3, p. 127.)

GUNNING, J. W. Arsenicumhoudend mineraal-water. *Nederl. Tijdschr. v. Geneesk.*, Amsterdam, 1880, xvi, p. 743. (Index Medicus, 1881, No. 3, p. 125.)

LIVEING, R. Notes on the treatment of skin diseases. 5th ed. London, 1881. (Index Medicus, 1881, No. 5, p. 233.)

MAUREL. Note sur les greffes dermo-épidermiques dans différentes races humaines. *Compt. rend. Soc. de Biol.*, 1878, Paris, 1880, 6 s., v, pt. 2, p. 17. (Index Medicus, 1881, No. 4, p. 150.)

MIELCK, W. J. Ueber eine neue Form, in welcher Medicamente der Haut applicirt werden Können. *Berlin. Klin. Wochenschr.*, 1881, xviii, pp. 284, 297.

RODDICK, T. G. Case of extensive varicose veins cured by partial excision, with antiseptic precautions. *Canada Med. & Surg. Journ.*, Montreal, 1880-1, ix, p. 449.

SMITH, W. G. Notes on the treatment of diseases of the skin. *Dublin Journ. Med. Science*, 1880, 3 s, lxxi, pp. 395, 415.

EXUDATIVE OR INFLAMMATORY AFFECTIONS, INDUCED BY INFECTION OR CONTAGION.

By W. A. HARDAWAY, M.D.

Bath treatment in scarlatina.—Dr. MANSON FRASER has put to a thorough test the bath treatment of scarlet fever in the Metropolitan Fever Hospital at Hemisten. The number of cases so treated was twenty-six; the number of baths administered varied from one to six in twenty-four hours. The age of the patients varied from two and one half to sixteen years. The duration of

the baths was from two to ten minutes. In cases where it was desired to lower the temperature while the patient was in the bath, this was accomplished by introducing the cold water through a piece of rubber tube reaching well under water. The patient is immediately returned to bed when taken from the bath, the drying being done in bed. Occasionally it was deemed best to give stimulants during immersion, to prevent collapse; and a small quantity was frequently given on returning the patient to bed, to increase the cooling effect and aid in the production of sleep. The indications for the use of the bath he considers to be two, viz., an elevation of the axillary temperature to 103° or 102.5° , where there seems to be special intolerance of high temperatures, and nervous excitement; and, of course, the indication is all the stronger when there are both hyperpyrexia and great nervous excitement.

He says when the heart's action is weak and the pulse feeble, the bath is not to be thought of. In some few cases of very young children the bath produces very great excitement, and in such cases the treatment should not be continued. As to the effects of the bath, it was found that after warm baths the temperature fell 3° to 4° F., but rose again rapidly, regaining its former height in about an hour. After baths that were cooled during the immersion of the patient, the temperature fell 4° or more, and the rise was rapid unless the immersion was prolonged after the cooling so as to be in effect a cold bath, when the lowering of temperature was more pronounced and lasted longer. When cold baths (60° to 70°) were given the fall of temperature was always decided, sometimes as much as 7° , and did not regain its former height for three or even six hours. It was not found that the temperature continues to fall for half an hour or more after removal from the bath, as is the case in enteric fever. The effect upon the nervous system was always soothing, often inducing sleep. The effect on the circulation was to diminish the force and volume of the pulse, and less notably, also, its frequency; during the immersion the pulse became small, thready, almost imperceptible, gradually regaining its former quality after the bath.

While in the bath the breathing became jerky, interrupted, and panting. After the bath the frequency of respiration was, as a rule, not materially affected. The influence upon the respiratory tract was, on the whole, favorable.

As to the sequelæ of the disease he does not think that any material effect could be attributed to the particular treatment adopted.

Dr. Fraser considers that this treatment is a valuable therapeutic agency in this disease.—*Practitioner*, July, 1881.

Real position of r  theln, rubeola, or German measles.

—Dr. WILLIAM SQUIRE, in a paper read at the late *International Medical Congress*, gave a short historical survey of the literature of the disease, and showed that it was known before it received a

distinctive name. The disease, in his opinion, has but a superficial resemblance to scarlet fever, but has close relations to measles in several points. But it is self-protective, is as distinct from measles as varicella is from small-pox, and possesses all the marks of a specific disease. It is contagious; it runs a definite course; it occurs but once in the same person.

Dr. KASSONITZ stated that: 1. In the epidemics of r \ddot{o} theln which have come under his notice, he has never observed the affection to pass into true measles. 2. The resemblance to measles is, nevertheless, sometimes so marked, both as regards the eruption and the associated phenomena, that in any single case the distinction from the milder form of measles, which runs a rapid course, is extremely difficult, and, in such circumstances, can only be made by having regard to other cases in the same house or locality. 3. If this affection has any special relationship to any other acute exanthem, it is to measles, not scarlatina, that it is allied. Dr. J. Lewis Smith drew the conclusion, from a large number of cases observed by himself, that r \ddot{o} theln is a distinct specific disorder. It is an exanthematous fever, mildly contagious. It resembles varicella in general mildness of symptoms, in the absence of dangerous complications, or sequelæ, and in the uniformly favorable progress, while its history and symptoms show a resemblance to measles and scarlet fever. Its incubative period varies from seven, or perhaps fewer, to twenty-one days.—*Am. Jour. Med. Sci.*, Oct., 1881.

Existence of two distinct forms of eruptive fever, usually included under the head of measles, and the relation to them of so-called rubeola, or r \ddot{o} theln.—Dr. W. B. CHEADLE, of London, at the recent Congress, read a paper with the title above, of which the following is an abstract:

That one attack of a contagious disease confers upon the individual who experiences it immunity from any further attack of the same disease, is a rule which has been found to hold good with regard to measles as generally as it does in the case of scarlatina or small-pox. Yet in two recent epidemics, both of them of severe and pronounced type, which followed one another in the same district within the year, it was found that the individuals who suffered in the first epidemic obtained no immunity from the second; and, further, that no previous attacks whatever of ordinary measles exercised any protective power against the second epidemic. Of 30 cases of the second epidemic, in which absolutely reliable histories could be obtained, 22 of the patients had had measles before, and ten of them, under the author's observation, within the year.

Certain deviations from the common type, such as a shorter period of incubation, severe laryngeal symptoms, and other special symptoms and other special features, taken together with the fact that previous attacks of ordinary measles conferred no protection, proved the disease of the second epidemic to be an essentially distinct exanthem. The question then arises whether it was a new and

unrecognized type of eruptive fever, or the only other known form of measles, r  theln. The exceptionally severe and even malignant character of the disease at the outset would seem to negative the idea of r  theln, which is always described as a disease of an invariably mild type. But after weighing all the facts, the conclusion is arrived at that the disease was r  theln, which prevails not only in the slight form which is acknowledged, but in a severe and malignant form also, hitherto unrecognized as r  theln, but erroneously described as an exceptionally severe variety of common measles.—*Am. Jour. Med. Sci.*, October, 1881.

Desquamation following scarlatina.—Mr. RIX, of the Fever Hospital, Bradford, states that in cases of fever, attended with intensely bright scarlet rash and high temperature, the desquamation may be completed in thirty days; that the great majority of cases, however, require from sixty to ninety-two days before they are fit to be discharged. In many cases, after six weeks' quarantine, it is extremely doubtful whether the old thick skin from the heels has quite fallen off. That the dead skin from scarlatinal patients does carry infection, there appears to be but little doubt; but that other factors are at work also appears certain, for frequently patients have been discharged, after all evidence of desquamation had long disappeared, the hair had been cut off short, the clothes had been changed, and every precaution taken to avoid infection, yet fresh cases have occurred within a week of the patient mixing with his brothers and sisters.—*London Medical Record*, July, 1881.

(Dr. Page, in the *Lancet* for Feb. 12, declares that even in slight cases desquamation is long delayed. Five weeks have, to his knowledge, elapsed before any, although carefully watched for, had made its appearance. He observes that slight cases require more observation than severe ones, in order to avoid sequel   and risks of contagion. He regards no scarlatinal patient as safe from conveying contagion for eight weeks and even more.—REPORTER.)

Pilocarpin in scarlatina.—Prof. DEMMCE, in the course of a paper on pilocarpin in scarlatina and diphtheria, says that in those cases of the former disease where there is a delay in the appearance of the eruption, or when it is incomplete, and at the same time when there take place dangerous cerebral symptoms, as sopor, convulsions, etc., an energetic diaphoresis, effected by pilocarpin, by subcutaneous injection, will remove in the quickest way from the blood the scarlatinal poison circulating therein; will bring out the eruption more completely, generally in an intense degree, and in this way put a stop to the cerebral symptoms. Pilocarpin has no power to ward off or prevent the nephritis, whether in an earlier or later stage of the disease, by its employment regularly from the beginning or during the stadium florionis. On the other hand, it is an effectual remedy against dropsy as a symptom. The course of the kidney affection appears

also a more favorable one under its use.—*Fahrh. f. Kinderheilkunde*, xvi Band, Heft 3 and 4, March 31, 1881; *Boston Med. and Surg. Jour.*, July 21, 1881.

Small-pox and revaccination. In a forcible editorial in the *Boston Med. & Surg. Jour.* there is presented a table of two columns, the one showing the percentages of decedents at selected ages, in 1872; the other showing the percentages of inhabitants living at the same ages to the aggregate population. An analysis of the table shows that children until five, although constituting but 12.5 per cent. of the population, contributed 26.5 per cent. of all deaths by small-pox; while youths between 5 and 15, making 18.5 per cent. of the living, contributed only 5.8 per cent. of the decedents. The contrast between these two sets of figures is considered as very striking, and shows, in the most peremptory manner, the deficiency of protection in the first years of life, and the efficacy of vaccination practised later on at the ages of school attendance. A further examination of the table shows that the relative degree of exemption enjoyed during adolescence, and resulting from the postponed vaccination, undergone in obedience to the requirements of school attendance, is seen to gradually disappear, so that it is found again, between the ages of 20 and 30, that a marked liability to fatal variola is once more reached. This is said to bear but one interpretation: we here see evidence of an inefficient practice of revaccination, which measure of prevention is shown to become necessary within a space of 8, 10, or 12 years after the first vaccination usually undergone in childhood. Later in life, at ages from 30 to 40 and upward, the liability to small-pox is known to diminish considerably, independently of preventive measures, and the figures show this to have been the case in Boston.—*Boston Med. & Surg. Jour.*, Feb. 10, 1881.

Vaccination revived. Mr. F. A. L. SHEPHARD, in the *Lancet*, June, 1881, reports a case of a nurse whom he vaccinated on the *right* arm, unsuccessfully, in four places, four years ago. Lately he again vaccinated her on the *left* arm in four places, producing one well-marked vaccine pustule. In a few days the four places on the *right* arm threw out distinct areolæ, and showed tolerably characteristic marks of successful revaccination. The reporter in the *London Medical Record*, July 15, 1881, commenting on this case, mentions the observation of Mr. Byerly, where pustules developed two months after vaccination.—*Med. Times & Gaz.*, Oct., 1881.

(In the same journal just quoted, Dec., 1877, Sir T. Watson mentions the case of a girl who was vaccinated when an infant, and in whom the spots became again well-developed pustules during an attack of influenza, fourteen years subsequently!—REPORTER.)

Clinical study of the accidents occurring during convalescence from variola. Dr. LEUDET, of Rouen, concludes

a long and interesting article on this subject, as follows : 1, That variola may present during convalescence complications found in other diseases, viz.: typhoid fever, rubeola, scarlatina, and rheumatism. 2, These complications are dropsies, with or without albuminuria ; nervous derangements,—loss of memory for words ; peripheral neuritis ; parotiditis ; gangrene of the mouth ; and necrosis. 3, These accidents are more particularly met with in epidemics of an adynamic character. The paper contains a number of cases illustrating these conclusions.—*Archives Gén. de Méd.*, June, 1881.

Recovery from Hemorrhagic variola. GAYTON records, in the *British Medical Journal*, April, 1881, p. 561, an unusual case of recovery from an attack of hemorrhagic small-pox, in a girl, aged 11, which from its continuity was originally hopeless ; observations in eight thousand cases not having included a similar instance.—*London Med. Record*, May 15, 1881.

(Schuyler, *Med. & Surg. Rep.*, Feb. 19, 1881, reports two recoveries from this form of variola, both patients being adults. Leudet, in the *Archives Gén. de Méd.*, June, 1881, mentions five cases of hemorrhagic small-pox which were restored to health.—REPORTER.)

To prevent pitting in variola. CARRICK recommends the application of rubber in chloroform as first suggested by Smarth, of Edinburgh, in 1863. A four-ounce bottle half full of chloroform, is to be filled three-quarters full with small pieces of pure rubber. It should be shaken every hour until the rubber is dissolved, making a thick liquid of the consistency of molasses. The face must be painted with this solution, beginning as soon as the eruption appears, and repeating it from three to five times a day. As the chloroform evaporates speedily, a thin film of pure rubber remains upon the surface, and protects it from the action of the air. The application must be kept up till the crusts begin to loosen upon other portions of the body.—*Phys. & Surgeon*, June, 1881 ; *St. Louis Courier of Med.*, Aug., 1881.

Treatment of malignant pustule. M. VERNEUIL, after enumerating the treatments in use up to the present day, including M. Davaine's latest researches on the anti-anthraxoid properties of iodine, arrives at conclusions which are intended to embrace all the means which had proved successful. He said that the malignant pustule consists of three zones : first, the gangrenous zone with its crown of vesicles ; secondly, an indurated zone presenting on its surface other vesicles ; thirdly, surrounding the latter a zone of unlimited extent, œdematous, with or without redness, and with or without sensibility on being touched. Hence each one of these regions requires a special treatment. For the gangrenous zone, total destruction with the thermo-cautery ; for the zone of induration, deep incision and cauterization ; and for the zone of œdema, hypodermic antiseptic injections, which

should consist of iodine in the quantity of ten drops of a one-half-per-cent. solution. The internal treatment consists in the administration of iodine, two to four drops every two hours.—*Archives Gén. de Méd.*, March, 1881.

Charbon.—M. PASTEUR in the course of his address on the germ theory, before the *International Congress*, after referring to the successful issue of his researches upon chicken-cholera, asks if we may not in a similar way discover the vaccine (?) of all virulent diseases. Inspired by this hope he, assisted by MM. Chamberlond and Roux, began a series of investigations to discover the vaccine of charbon. We cannot forbear quoting his own characteristic words:—"At the outset we were met by a difficulty. Among the inferior organisms, all do not resolve themselves into those corpuscle germs which I was the first to point out as one of the forms of their possible development. Many infectious microbes do not resolve themselves in their cultures into corpuscle germs. Such is equally the case with beer yeast, which we do not see develop itself usually in breweries, for instance, except by a sort of semiparity. One cell makes two or more, which form themselves in wreaths; the cells become detached, and the process recommences. In those cells real germs are not usually seen. The microbe of chicken-cholera and many others behave in this way, so much so that the cultures of this microbe, although they may last for months without losing their power of fresh cultivation, perish finally like beer yeast which has exhausted all its aliments. The anthracoid microbe in artificial cultures behaves very differently. In the blood of animals, as in cultures, it is found in translucid filaments, more or less segmented. This blood or these cultures, freely exposed to air, instead of continuing according to the first mode of generation, show at the end of forty-eight hours corpuscle germs distributed in series more or less regular along the filaments. All around these corpuscles matter is absorbed, as I have represented it formerly in one of the plates of my work on the disease of silk-worms. Little by little all connection between disappears, and presently they are reduced to nothing more than germ dust. If you make these corpuscles germinate, the new culture reproduces the virulence peculiar to the thready form which has produced these corpuscles, and this result is seen even after a long exposure of these germs to contact with air. Recently we discovered them in pits in which animals dead of splenic fever had been buried for 12 years, and their culture was as virulent as that from the blood of an animal recently dead. Here I regret extremely to shorten my remarks. I should have had much pleasure in demonstrating that the anthracoid germs in the earth of pits in which animals have been buried are brought to the surface by earth-worms, and that in this fact we find the whole etiology of the disease, inasmuch as the animals swallow these germs with their food. A great difficulty presents itself when we attempt to

apply our method of attenuation by the oxygen of the air to the anthracoid microbe. The virulence establishing itself very quickly, often after four-and-twenty hours in an anthracoid germ which escapes the action of the air, it was impossible to think of discovering the vaccine of splenic fever in the conditions which had yielded that of chicken-cholera. But was there, after all, reason to be discouraged? Certainly not; in fact, if you observe closely, you will find that there is no real difference between the mode of the generation of the anthracoid germ by scission and that of chicken-cholera. We had therefore reason to hope that we might overcome the difficulty which stopped us by endeavoring to prevent the anthracoid microbe from producing corpuscle germs, and to keep it in this condition in contact with oxygen for days and weeks and months. The experiment fortunately succeeded. In the ineffective *bouillon de poule* the anthracoid microbe is no longer cultivable at 45° C. Its culture, however, is easy at 42° or 43° , but in these conditions the microbe yields no spores. Consequently it is possible to maintain in contact with pure air at 42° or 43° a *mycélienne* culture of bacteria entirely free of germs. Then appear the very remarkable results which follow. In a month or six weeks the culture dies—that is to say, if one impregnates with it fresh *bouillon*, the latter is completely sterile. Up till that time life exists in the vase exposed to air and heat. If we examine the virulence of the culture at the end of two days, four days, six days, eight days, etc., it will be found that long before the death of the culture the microbe has lost all virulence, although still cultivable. Before this period it is found that the culture presents a series of attenuated virulence. Every thing is similar to what happens in respect to the microbe in chicken-cholera. Besides, each of these conditions of attenuated virulence may be reproduced by culture; in fact, since the charbon does not act a second time each of our attenuated anthracoid microbes constitutes for the superior microbe a vaccine—that is to say, a virus capable of producing a milder disease. Here, again, we have a method of preparing the vaccine of splenic fever. You will see presently the practical importance of this result, but what interests us most particularly is to observe that we here have a proof that we are in possession of a general method of preparing virus vaccine based upon the action of the oxygen and the air—that is to say, of a cosmic force existing everywhere on the surface of the globe.” The speaker further said that by a physiological artifice all these forms of attenuated virus may easily be made to recover their original maximum virulence. The annual loss of animals from splenic fever in France is of the value of 20,000,000f.; therefore M. Pasteur was asked to put his researches to a practical test. Fifty sheep were placed at his disposal, of which twenty-five were vaccinated. A fortnight afterward the fifty sheep were inoculated with the most virulent anthracoid microbe. The twenty-five vaccinated sheep resisted the infection; those unvaccinated died of splenic fever within fifty hours.—*Medical News and Abstract*, Oct., 1881.

Anthrax.—It has been ascertained by Duguid and Sander-son that bovine animals inoculated with anthrax virus suffer only from a very mild form of the malady; chiefly consisting in a febrile rise of temperature, which, however, after a few days leads to perfect recovery. Animals so inoculated remain safe against further contagion. Professor GREENFIELD (*The Veterinarian*, October, 1881), by new and important experiments, fully confirms, and to a considerable extent extends, the above results. Four heifers, A, B, C, and D, were used for experiment. Heifer C was inoculated with cultivated bacillus anthracis of the third generation. The next day the animal showed rise of temperature and other signs of constitutional disturbance, besides swelling at the seat of inoculation. About the fourth day both the local and the general symptoms had reached their maximum (temperature 106°) and then declined. On the eighth day recovery had set in. No pustules had been observed during the illness in any part of the skin, nor had bacilli been found in the blood of the ear. At the end of ten weeks, the animal being in perfect health, it was again inoculated, but this time with anthrax virus from the guinea-pig. The spleen of the animal, swollen and swarming with bacilli, was reduced to a pulp, mixed with water, and the entire quantity injected beneath the skin of the flank of the above heifer. Not the slightest symptom, either local or general, followed this inoculation. Heifer D was inoculated with the eighth generation of artificially cultivated bacillus anthracis. Only a slight rise of temperature was observed the next day. A week later it was again inoculated with the seventh generation of cultivated bacillus anthracis, but without any other effect beyond a small local swelling. Three months later it was inoculated with half a drachm of blood of a man, a wool-sorter, who had died of general anthrax (wool-sorter's disease). The blood was fresh and swarming with bacilli. Inoculated into rodents, this blood produced typical anthrax. The heifer D thus inoculated suffered from a very severe illness, rise of temperature, great general prostration, and much local swelling. On the fifth day the condition began to improve, and the animal speedily recovered. A month later both heifers, C and D, were inoculated with the blood of a cow that had died of splenic fever. This blood produced typical of anthrax in rodents, and was swarming with bacilli. In heifer C a slight rise of temperature (half a degree) was observed on the following day, but in neither case were there any symptoms indicating disease. Two other heifers, A and B, having been five months previously inoculated, and thus made immune, were subjected to subcutaneous inoculation with one drachm of blood (swarming with bacilli) of a sheep that had died of general anthrax. No effect was produced. Subsequently the heifers A, C, and D, were placed under conditions in which they in all probability would have contracted splenic fever, had they not been made immune by previous inoculations. They were transferred to fields in a sewage farm at

Harden, near Bingley, in which several cases of anthrax in cattle and sheep had occurred previously to and after their arrival. These fields were supplied with sewage, by far the larger quantity of which consisted of "sud-water" of a mill where bad van mohair is used. Several cases of wool-sorter's disease had occurred among the workers of this mill, and it is now known that van mohair is often considerably contaminated with anthrax virus. From Dr. Greenfield's inquiry, there can be little doubt that the cases of anthrax in cattle and sheep that occurred in this sewage farm were directly due to the poison of anthrax conveyed in the sud-water from the mill to the fields. The above heifers, A, C, and D, were kept in these fields for three months, and although two cases of anthrax had subsequently occurred in sheep pasturing in these fields, the heifers remained well.—*London Medical Record*, November 15, 1881.

Period of immunity after the occurrence of splenic fever, etc.—Prof. SEMMER, of Dorpat, gives a short and interesting summary of the recent studies of Pasteur, Toussaint, and others, in regard to what may be termed preventive viruses.

Perhaps he further says, practical results in the same direction might be obtained in the case of prostitutes by injecting into the veins properly attenuated syphilis virus (?). The practical part of his paper deals with the important question as to the period of immunity obtained by these preventive inoculations in splenic fever, etc. He may justly say that the discoveries of Pasteur and others would lose much of their practical importance if this immunity period were found to be very short. In the case of rabbits which had been rendered insusceptible to septicæmia by inoculation, S. found that after three months they had become again susceptible. At the same time it was discovered that within twenty-four hours after death, the blood of animals which had succumbed to splenic fever was no longer capable of reproducing the disease, while it produced virulent septicæmia. Furthermore, it was found that the septic material lost all its power if it were heated too long, or brought to too high a temperature, that is, if the albumen were coagulated or dissolved. Prof. Raupach and Semmer ascertained that the contagium of cattle plague lost all of its septic power after being heated to 55° C. Cohn has also shown that the contagium of splenic fever is rendered inert by a temperature exceeding 55° C.

Tisbot inoculated two sheep with the unmodified contagium of splenic fever three months after a successful preventive inoculation, and both the animals succumbed to the disease. From this it is evident that the preventive inoculation should be frequently repeated in the case of septicæmic and splenic fever, as the immunity is only temporary.—*Centralbl. f. die Med. Wissenschaften*, No. 10, Oct. 1, 1881.

Treatment of recurring erysipelas of the face.—Dr. JAMES BRAITHWAITE, of Leeds, says that frequently recurring

erysipelas of the face is very annoying to the patient, for in spite of every precaution it will return again and again. After attention to the hygienic surroundings and the general health some local treatment is requisite, but that then applications are, as a rule, either disagreeable or disfiguring. For many years B. and his father have used with entire success a strong solution of tannin—four to eight grains to the drachm of spirits of wine and water. This application, which is not disagreeable, should be painted over the affected parts with a soft brush every two or three hours, and allowed to dry, the patient being careful to keep the face from the fire. He says that this solution will always avert a threatened attack.—*British Med. Jour.*, April 30, 1881; *Practitioner*, Sept., 1881.

Salicylate of sodium in erysipelas.—HALLOPEAU recommends the internal and external use of the salicylate of sodium in erysipelas, and claims that under its use the duration of the disease was much abridged. The temperature was lowered in those cases which presented febrile disturbance. The author had not observed any of the accidents which sometimes follow the same doses of the drug when administered in typhoid fever. In one case only was there slight temporary delirium, which probably was not due to the medicine. The method of administration is as follows: 1. The application of compresses wet with a solution of 1-20; then to be covered with oiled silk and frequently renewed. 2. Internal administration daily of four grammes in three doses, given in weak grog.—*L'Union Méd.*, May 1, 1881; *N. Y. Med. Jour.*, Sept., 1881.

Relapsing Measles.—In the *Boston Society for Medical Improvement* a number of cases of so-called second attacks of measles were reported. Dr. AYRES had a case in which a second attack came on in twelve days after the first. Dr. GOSS spoke of a case where there was an undoubted recurrence of the disease within three weeks after the first attack. Dr. WHITE reported a case where it occurred twice in eight days; Dr. WADSWORTH one which recurred in three weeks. The same subject was brought up before the Section on Diseases of Children, of the *American Medical Association* (Richmond, May 4, 1881). In reply to a question as to whether measles ever occurred twice in the same person, Dr. ROTCH stated that during the epidemic which had lately prevailed in Boston, measles had been observed to occur not only twice but three times in the same person; Dr. SELDEN had never seen measles occur twice. Dr. LEE did not believe that measles ever occurred twice in the same person, but considered that such cases were instances of rötheln. Dr. ATKINSON, of Baltimore, said he had undoubtedly seen numerous cases of recurrent measles. Dr. JACOBI said he believed that true measles occurs two, three, or four times.

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ANTHRACÆMIA (WOOL-SORTER'S DISEASE).

- BALLARD. The manufacture of horse-hair. *Rep. Med. Off. Local Gov't Board*, 1878, London, 1879, viii, p. 43. (Index Medicus, 1880, No. 7, p. 320.)
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(The remainder of the recent literature is reserved for want of space.)

EXUDATIVE OR INFLAMMATORY AFFECTIONS;
ERYTHEMATOUS, PAPULAR, VESICULAR,
BULLOUS, AND PUSTULAR.

By H. W. STELWAGON, M.D.

Urticaria.—In the local treatment of this disease ROHÉ has found that the best and least unpleasant anti-pruritic application

is a lotion of a drachm of benzoic acid to a pint of water.—*Maryland Med. Journal*, vol. viii, No. 2, p. 25.

On the treatment of chronic urticaria.—LABBÉE, in reply to a question regarding the best treatment of those cases of chronic urticaria which prove rebellious to the usual remedies, lauds highly the arseniate of sodium. The drug is to be given in full doses. In conjunction with this the local application of a dilute solution of corrosive sublimate is recommended.

Blondeau also had found the remedy of signal value.—*Bull. et Mem. Soc. de Therap.*, iv, p. 41, Paris, 1881.

Case of herpes iris with albuminuria.—SAUNDBY reports briefly a case of herpes iris, in which albuminuria was found to co-exist. No casts were discoverable. The eruption was confined to the left hand and wrist. At the end of a week it had almost disappeared, and with it the albuminuria.—*British Med. Journal*, Lond., 1881, i, p. 511.

On herpes (hydroa) gestationis.—W. G. SMITH reports in detail a case of this disease. In some of its features the eruption bore an eczematous aspect. The patient was aged about 35 years. At the third pregnancy, when six months advanced, an eruption appeared around the umbilicus like a "ringworm." It spread rapidly over the trunk and limbs, but spared the face. It persisted during gestation, and for two months subsequently, when it gradually disappeared. There was considerable irritation of the skin present, itching and burning being prominent symptoms. She remained perfectly free from the eruption for five years, then when three months pregnant with her seventh child it re-appeared, beginning around the umbilicus in the same manner as the first attack, *i. e.*, clusters of little papules or vesicles. The limbs were rapidly implicated. Within the first week of parturition the affection grew considerably worse, and spread over the chest and abdomen. Large vesicles and bullae formed, all tense and distended. When the child was three months old the eruption had nearly disappeared, but then relapsed. A gradual improvement finally took place. After the deliveries preceded by the eruption, the nails fell off; at a later period the nails were reformed, being marked, however, with transverse furrows. The disease was seemingly uninfluenced by treatment.—*Dublin Jour. Med. Sci.*, 1881, 3 s., lxxi, p. 70.

Contributions to the literature of pemphigus.—In a report of a number of cases of pemphigus occurring in HEBRA'S wards, three are given in which death ensued.

In the first of these, pemphigus malignus, the affection had already existed fifteen months. Ten days before death the patient, a female, aged 41 years, was brought to the hospital. The condition then noted was as follows: The eruption was distributed over the whole body. Pigmented spots marked the site of old bullae. Blebs in various stages could be seen over the trunk,

limbs, and face, none fully distended, but all more or less flaccid. Occasionally imperfect blebs appeared on the mucous membranes of cheeks. General condition was poor. Autopsy showed, excepting the skin lesion, nothing abnormal.

In the second case, pemphigus foliaceus, the patient was a male, aged 50 years. The disease had made its appearance two months before admission to the hospital, and, as described, began as pemphigus vulgaris. Finally, new blebs appeared at the periphery of older ones, and the affection assumed the characters of pemphigus foliaceus. The eruption was scattered over the trunk, limbs, and face. In places the blebs had been scratched or rubbed and the epidermal wall removed, leaving excoriated surfaces, secreting a sero-purulent fluid. These patches varied in size from a ten-cent piece to several inches in diameter. At their peripheries there were new blebs, or a rim of loose epidermis, and in the centres, some covered with thick dry crusts. In some places on the skin the bullæ had disappeared as such, leaving a thick crust. The lips were crusted, dry, and fissured. Some portions of the mucous membrane of the mouth were completely denuded of epithelium, and, as likewise with the tongue, looked macerated. All over the body there were pigmentary stains from former bullæ. The urine contained a small proportion of albumen. Death followed fourteen days after admission. During this time new lesions continued to appear, especially at the peripheries of the already-existing patches. In this manner a great part of the whole integument became involved in the disease. The tongue swelled and grew intensely red, and in places was covered with a thick, adherent, yellowish-white membrane. Death was preceded by exceeding rapid breathing, indicating pulmonary implication or complication. Autopsy: universal marasmus, œdema of the lungs; pemphigus, with numerous patches on skin, and some on mucous membrane of mouth and pharynx.

In the third case of this interesting group the patient was a male, aged 33 years. In youth he had been "scrofulous"; since that time perfectly healthy. Nine months before admission an eruption appeared on the upper section of the back, and at about the same time, at the region of the left trochanter and left nipple, some flat blebs made their appearance. Condition presented at time of admission: At the site of the eruption on the back, referred to above, were red, pigmented, sharply-defined patches, with small scar-like areas scattered over them. On other parts of the back, intensely red, weeping surfaces, denuded of epidermis, and of the diameter of one half to two inches, with a loose rim of epidermis at the edges. A hazel-nut-sized bleb on the right arm and one on the finger, filled with pus. On the scalp were isolated crusted patches. On the neck, confluent areas, healed over in the centre, at other parts covered with a whitish deposit; at the periphery the epidermal skin was loose and raised. Both lips were crusted. The mucous membrane of inside of lips denuded, and in parts raised in folds. On mucous membrane of

cheeks and hard palate, sharply defined, ten-cent-piece-sized denuded spots. About the symphysis pubis, inguinal region, and inner side of thighs were papillary excrescences, smeared over with a stinking discharge. At places along the periphery of these were irregular, baggy, semicircular patches, each having in the centre papillary granulations and surrounded with a bleb wall, and a red halo. On the left thigh, inner side, were several circinate patches partly covered with crusts, and partly free, weeping surfaces. On the extensor surface of the right knee was a patch the size of a dollar, with the centre healed, and the periphery a continuous bleb. In both axillæ were several pea-sized pustules. In the progress of the case after admission, while under treatment, new blebs appeared on healthy parts and also at the edges of the older patches. While in continual bath, toward the final close, some places healed, but the strength rapidly failed. A few days before dissolution incessant vomiting occurred. Death ensued nineteen days after admission. No autopsy.—*Wien Med. Presse*, 1881, xxii, pp. 111, 175, 236.

(There are histories of other cases given in the communication, which are exceedingly interesting, especially those of the pruriginous variety. The notes on treatment are somewhat indefinite in the original, and are therefore omitted in the abstract above. The bath, in most of the cases, seems to have played a prominent part.—REP.)

Impetigo contagiosa.—RIEDEL, from an observation of a series of cases, thinks the definition of the affection as given by Kaposi sufficiently clear and comprehensive:—

“Impetigo contagiosa is characterized by an acute eruption of superficial vesicles, varying in size from a pin-head to a lentil, and occurring on the region of the face; arising as discrete vesicles and rapidly drying into gummy crusts, under which the skin resumes its normal condition. Intense swelling of the sub-maxillary glands accompanies the eruption.”

Riegel considers the disease as distinctly eczematous, and suggests the name “eczema impetiginodes contagiosum.” As others, he discovered a fungus in some crusts; but as he was unable to detect such in the vesicles, and could not find any trace of it in crusts or vesicles produced by inoculation on himself, the occurrence was looked upon as accidental or secondary. The possibility of irritation of pediculi being the cause is repudiated. The disease is undoubtedly contagious,—of the nature of the contagion, however, we are in ignorance.

The duration of the cases varied; in some as many as three months elapsing before entirely disappearing, and in others the affection ran its course in a few weeks.

In one case given, the eruption was confined to a small patch, which, apparently about to disappear, was reproduced and thus continued for several months.—*Berlin Klin. Wochenschr.*, 1881, xiii, p. 179.

(The definition as given above is in many particulars a faulty one, especially in respect to the distribution of the eruption. Although in numerous instances the face is the only part affected, still it is far more common to see cases in which patches occur both on the face and hands, and it is not infrequent that the face is entirely free and the eruption seated elsewhere. Indeed, such exceptions occur in the cases reported by Riegel, in his communication.—REP.)

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HERPES AND HERPETISM.

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NEW FORMATIONS.

GEORGE H. TILDEN, M. D.

Malignant papillary dermatitis of the nipple.—Dr. THIN reports the microscopical appearances of four specimens of this lesion (known as Paget's disease), and sums up as follows: The microscopical examination of the skin proves that the disease is not eczema, but an inflammatory infiltration into the superficial layers of the cutis, combined with destruction of the connective tissue thereof—a destruction which never takes place in true eczema. In distinguishing clinically this malignant dermatitis from eczema, the chief points to be borne in mind are the well-defined margin of the former, and the evidence to the touch of infiltration into the papillary layer of the skin. An eczema of the areola, which had the thickening and moist redness which characterize this affection, would be extremely acute in its nature. This malignant dermatitis has neither the symptoms nor the pathological anatomy of any known skin disease. It is characterized by destruction of connective tissue, and by permanence of the destructive process, for repair of the destroyed elements of tissue does not take place. The condition of things in the breast in the early stages of the disease before any tumor can be felt, requires further examination. In a case described by Mr. Butlin (*Med. Chir. Transactions*, vol. 59, p. 108), in which the breast was removed merely on account of the condition of the skin, the milk ducts for an inch or more beneath the nipple were found to be completely stuffed with epithelium. Regarding the

nature of the breast tumors which follow this disease of the nipple, they are not the ordinary scirrhus or parenchymatous cancer of the breast, but are so-called "duct cancers" or the fibro-carcinoma cysticum mammæ of Waldeyer. In these cases the tendency of growth is in round columns, which as they grow larger coalesce into round masses, the disposition to penetrate and infiltrate the interlobular connective tissue of the breast being but small. The growth of these tumors is regular, symmetrical, and centrifugal, and occasionally small cysts are formed by the breaking down of the cells contained in the central portions of the growth. The differences between these tumors and those usually known in England as adenomata are rather of degree than of kind. When an epithelial growth in the breast takes its origin in the epithelium of the milk ducts, if the development of columns and tubes (made up of hyperplasia of duct epithelium) is localized and encapsulated by a growth of connective tissue, the tumor is an adenoma. If, on the contrary, there is progressive destruction of connective tissue and continued growth of the original tumor, the tumor is a so-called "duct cancer" (fibro-carcinoma cysticum mammæ of Waldeyer).—*British Med. Journal*, 1881, 1, pp. 760, 798.

Treatment of lupus.—BESNIER gives his testimony in favor of the treatment of lupus by means of scarifications. The operation consists in scarifying in every direction, and methodically, the diseased surface. The cutting edge of the instrument used should always be kept at right angles to the surface operated upon. In this way the tops of the papillæ and the interpapillary depressions are left nearly intact, and the layer of the skin necessary to the regeneration of the epithelium is preserved for future usefulness. The nearer together and the more regular the scarifications, the greater are the chances of a rapid success. The depth to which the instrument should penetrate is measured by the resistance offered, which, very feeble on the part of pathological tissue, becomes, on the contrary, very appreciable in the sound tissue. Blood flows freely, so that frequent sponging is necessary to keep the field of operation clear. The after-treatment consists in the arrest of hemorrhage by the use of sponges and of silk paper, and the subsequent application of emplastr. de Vigo, other than which no dressing is required. As a rule, the scarifications are healed in about eight days, and may then be renewed. In old cases renewal of the treatment from time to time in after years is necessary. It is especially in lupus verax of the face that the scarifications should be made early and conducted with vigor (sévèrement). This method of treatment applied to lupus erythematosus gives about as many failures as successes. The absence of any bad results due to the operation is remarkable, Besnier in a series of one thousand cases having met with no untoward accidents. The operation, according to Besnier, fully justifies the claims made for it by Balmanno Squire :

1. That from the moment this method of treatment is established the progress of the disease is checked.

2. That reparation of tissue and restoration of the diseased organ (nose) ensues to an extent seemingly impossible.—*Bulletin gén. de Thérapeutique*, 1881, No. 1, p. 1.

Liomyoma cutis.—BESNIER reports a case of dermato-myoma which came under his observation in 1876. The patient was a woman sixty years of age, thin, anæmic, and suffering from emphysema of the lungs, chronic bronchitis, and chronic rheumatism. She presented on the body and upper limbs an eruption consisting of :

1. Spots the size of a lentil, of a faint rose color slightly elevated, round or irregularly oval in shape, analogous to the lesions of papular urticaria.

2. Tumors of the form and size of small shot, of a pea, or of a lentil, rose-colored, the color of the larger ones passing into a dull red. This color was due to the presence of blood, and disappeared upon pressure. Nowhere was there pigmentation. The surface of the tumors is smooth, they being covered with normal epidermis. There was no itching and not a trace of scratching. Moderate pressure upon the larger elements of the eruption excites pain. The individual lesions are firm in consistence. The eruption had made its appearance about three months before and did not inconvenience the patient in any way. It was distributed over the arms and body, the most marked development being in the right and left subscapular regions. During the early months of 1877 about twenty new spots developed themselves with extreme slowness, and several of the already existing nodules increased in size. By the latter part of 1878 the disease had advanced but slightly. No diagnosis was made, but two of the tumors were excised for microscopical examination. The wounds of excision healed readily; the resulting cicatrices were smooth, soft, and flat, and there was no return of the tumors a year afterward.

The epidermis was found to be thinned but normal. The tumors made up almost entirely of bundles of unstripped muscular fibres, running in every direction, both longitudinal and cross-sections being seen. These bundles were less abundant in the deeper layers of the tumors. The union of the tumors with the deeper layers of the skin was effected by thick fibrous bands, which take origin in the tumor and partition it in every direction. Blood-vessels were rare in the tumors and one or two small nerve-trunks were to be seen in the periphery. In the lateral and deeper portions of the tumors were to be seen the coils of sweat glands and globules of fat. The tumors occupy principally the middle and deeper layers of the true skin. After a sufficiently extended research into the literature, Besnier has been able to discover mention of but one case of genuine disseminated myomata of the skin, reported to the Société d'Anatomie in 1858, by Vernueil. Besnier concludes as follows :

Cutaneous myomata are of various species, between which we cannot as yet pretend to discriminate, but they may at least be divided into two principal classes.

1. Simple myomata, dermato-myomata properly speaking.
2. Dartrous myomata (originating from pre-existing muscular tissue in the skin).

The true dermato-myomata may be situated over the whole extent of the skin; their development is very slow, and they do not appear to reach a large size. They are always multiple, and with progression of development they may become highly vascular. Indolent and painless in the beginning, they may become painful and very sensitive upon pressure. Essentially benign in character, when excised they do not return. The affection is slowly progressive, belongs to adult life or old age, and it is improbable that internal medication influences it in any way. The relations of the disease, if it have any, with other morbid conditions escape us entirely. These tumors in all probability have usually been confounded with soft fibromata of the skin, but once recognized as a possibility among dermal tumors their diagnosis will not be difficult.

The second variety, the dartrous form of myomata, consists in tumors of a more variable evolution, sometimes multiple in the same region, but, as a rule, solitary. They have been met with in the mammary region, labia majora, scrotum and penis. They may reach the size of the clenched fist, but more often are the size of a nut,—an almond. They may be either with or without pedicle contract when irritated, are more or less vascular, and, like the true dermato-myomata, are of slow growth and benign character. —*Ann. d. Derm. et de Syph.*, tome i, No. 1, 2me série, p. 25, Jan. 25, 1880.

Liomyoma cutis.—Another instance of this rare disease is reported by Dr. SOLLES. The patient was a woman, 52 years of age, of robust constitution and habitual good health. Physical examination showed normal condition of all the organs except the skin. The disease had first made its appearance on the right forearm, about fifteen years before the patient entered the hospital, and had progressed slowly. In the character of the individual lesions and in the topography of their distribution the case did not essentially differ from that described by Besnier. The noteworthy feature of the case was the severe pain, both spontaneous and provoked by irritation, from which the patient suffered. Pressure, blows, and sometimes the mere friction of the clothing upon the tumors caused attacks of pain which, limited at first to the part irritated, extended in all directions. The application of a piece of ice to one of the tumors of the forearm provoked, after some seconds, an attack of pain sharp and severe enough to cause screams on the part of the patient. The crisis of pain lasted about five minutes and then gradually subsided. The patient also suffered from spontaneous neuralgic attacks. These

always started from the region of the forearm and, radiating in every direction, spread to the hand and neck. Of daily recurrence, they lasted from a few instants to several hours. An odd phenomenon attendant upon these attacks of pain was the anæmic condition, for the time being, of the tumors which were the seat of pain. If one of the tumors was pricked, after some seconds its color gradually faded and finally entirely disappeared. At this moment was the onset of pain, and the tumor remained discolored until the end of the attack, the color returning gradually as the pain disappeared. This peculiarity was constant. All the regions affected by the eruption were not the seat of pain to an equal extent, it being most severe in the forearm, the oldest habitat of the disease. The microscopical examination of one of the tumors which was excised, gave the same results as in Besnier's case.—*Annales de Derm. et de Syph.*, 2me. série, tome ii, No. 1, p. 60.

Bacillæ lepræ.—CORNIL and SUCHARD having made microscopical examination of several specimens taken from cases of tuberculous leprosy, report as follows: The leprous tubercles of the skin consist in an infiltration into the papillary and dermal layers of the skin of large globular cells, spheroidal or slightly flattened in shape, very numerous, and situated between the fibres of the connective tissue. The papillæ of the skin are no longer clearly marked at the level of the centre of the tubercle, and both glands and hair follicles are atrophied and destroyed. The epidermal layers are thinned to such a degree that the surface of tubercles, not yet in a state of ulceration, are devoid of hair. Specimens taken in the fresh state from the living patient and teased in water with needles, showed, in the fluid separating the elements of tissue, spherical grains and rods possessed of spontaneous movements. These rods bend and turn themselves. Small pieces of skin were excised from the living patient and were placed first in alcohol of 40° and then in absolute alcohol. The sections made from these were colored in a solution of methylaniline 5 B, one part to five of water, then washed successively in a solution of carbonate of soda, one part to four of water, and in absolute alcohol. Finally they were treated with oil of cloves and put up in Canada balsam. By washing in alcohol some of the coloring matter is removed from the protoplasm of the cells, and it is necessary to discontinue its action before the bacterial rods themselves are discolored. In successful preparations all the cells composing the special infiltration of leprosy are to be seen filled with numerous rods which are colored of an intense blue. The protoplasm of the cells is of a blue tint merely, while the fibres of the connective tissue are uncolored. These rods are rigid, immovable—an effect probably due to the action of alcohol. Some are separate, isolated; others gathered into bundles. There are but few rods to be seen outside the cells. No bacteria are to be found in the various layers of the epidermis, the inference being that the epidermal layers of the skin are impenetrable to

these bacteria. Bacteria were also found in various internal organs, notably in the liver of one case, which liver also presented the appearances of hypertrophic cirrhosis.—*Annales de Derm. et de Syph.*, 2me série, tome ii, No. 4. p. 653.

Leprosy.—The following conclusions with regard to the bacterial nature of this disease are given by Dr. ALBERT NEISSER, in *Virchow's Archivs* :

1. Leprosy is a true bacterial disease, caused by a special variety of bacteria.

2. These bacteria enter the organism as such, or more likely as spores, and remain in a state of incubation in certain depots, the lymphatic glands perhaps, for a longer or shorter period of time. The term of incubation of these bacteria varies greatly, not only as compared with the incubation stages of other infectious diseases, but also in different cases of leprosy. The incubation and progress of the disease appear to be much more rapid in tropical countries than in those parts of Europe where leprosy is endemic.

3. From the above-mentioned depots the disease spreads in the body, principally in the skin (*lepra tuberosa*), and notably in those regions exposed to insult, the face, hands, elbows, and knees, and also in the peripheral nerves (*lepra anæsthetica*). Other parts of the body, testicles, spleen, cornea, cartilages, and liver are less subject to invasion.

4. The bacteria or spores give rise to inflammatory processes in organs or parts of the body which are supplied with blood-vessels, but in those parts where there are no blood-vessels, to immigrations (*Einwanderungen*) from the periphery inward. The lymphatic cells, containing spores or bacteria, constitute the materials of which the special neoplasms of leprosy are made up. The specific action of these bacteria transform the ordinary wandering cell into the specific cell of leprosy, the shape, course, and disappearance of which are characteristic.

5. Probably leprosy is an infectious disease, and its specific products are contagious. The disease is not only directly contagious, but also indirectly so, its specific bacteria or germs being transferred by various objects.

6. Leprosy is not hereditary.—*Virchow's Archivs*, Band 84, No. 3.

Xanthoma.—Dr. CARRY reports a case of xanthoma which is unique in being independent of any hepatic lesion and unaccompanied by jaundice. The patient was a girl ten years of age, and the first manifestations of the disease had appeared shortly after birth. The family history threw no light upon the case, and the girl herself was in good health. She presented a yellowish coloration of the skin, due not to jaundice but to the presence of an abnormal quantity of pigment in the cells of the deeper portions of the Malpighian layer of the skin. The disease presented itself only in the tubercular form, the patient never having had maculæ

upon the skin. The eyelids were unaffected, and the tubercles were situated mainly over the prominences of the limbs. Over the olecranon, malleoli, and on the heel they were of larger size, and, extending through the skin, were attached to the periosteum and tendons. Microscopical examination showed the tumors to consist of a stroma, made up of large bundles of connective tissue. The cells lining the interstices of this stroma were in a state of granulo-fatty degeneration. The result of this process was the accumulation, in the compartments of the connective-tissue stroma, of fatty products of various aspect, often crystalline in form, presenting the morphology of crystals of tyrosin. The glands of the skin were not involved in the process. In the deeper layers of the rete mucosum was found a deposition of reddish-brown pigment, constituting a mild grade of melanoderma. On microchemical examination was found evidence of the presence of leucin and tyrosin in the tumors.—*Annales de Derm. et de Syph.*, 2me série, tome 1, No. 1, p. 64.

Micrococci of lupus.—For over a year past MAX SCHÜLLER has examined lupus with especial reference to the presence of micrococci. The portions of diseased tissue in which micrococci are most easy of detection, are the small, young nodules which, embedded in the connective tissue, underlie and surround the larger and older centres of the disease. The freshly excised bits of tissue were placed immediately in a one-per-cent. solution of carbolic acid in water, in order to exclude any accidental access of micrococci. Sections of these made with a Roy freezing microtome were colored in a one-per-cent. solution of methylviolet in water, washed to remove excess of coloring matter, and put up in oil of cloves or glycerine. By this process only the cells and micrococci are colored blue, while the connective tissue remains uncolored. Powers of 660 and 1,120 diameters were used, and Abbe's system of illumination with condensed artificial light. In the groups of round cells and single epithelioid cells which go to make up a lupus nodule, micrococci were seen situated between the cells and also surrounding the individual groups of cells. From various points in the periphery of such a group of cells, rows of micrococci ran out into the adjacent connective tissue, sometimes reaching as far as the next group of cells. As a rule the micrococci were not crowded together, but rather loosely distributed. In many specimens they were to be seen arranged around the large nucleated, epithelioid cells which lie scattered about in the neighborhood of the smaller lupus nodules. Each one of these large cells formed the centre of a group of micrococci which sent out offshoots in various directions into the surrounding connective tissue. In regions where these large cells were more crowded together, it was not unusual to see rows of micrococci running from one cell to another, and when several of such rows met, at the points of intersection ensued small star-shaped groups of micrococci. In the large and fully developed lupus nodules, micrococci are very diffi-

cult of detection by reason of the fact that the contained cells are very closely packed together. Nevertheless, in very thin sections micrococci may be seen sparsely scattered between the cells, and invariably are easy of demonstration at the points in the circumference of the larger nodules from which accumulations of cells extend in the form of long processes into the surrounding connective tissue. The free ends of such rows of cells are surrounded by groups of micrococci, which are also connected with the collections of micrococci belonging to the neighboring and smaller lupus nodules. Within the limits of diseased tissue micrococci were also found in the hyperplastic sebaceous glands, in the sheaths of the hairs, around the coils of the sweat glands, and occasionally in the walls of the smaller blood-vessels. In one case of superficial ulcerating lupus of the nose micrococci were found in the epidermis, between the hypertrophied papillæ of the skin. The younger the lupus formation and the softer the surrounding tissues, *i. e.*, the less amount of cicatricial tissue present, the more abundant and the more distinct are the micrococci.—*Centralblatt für Chirurgie*, No. 46, Nov. 19, 1881, p. 1.

Rhinoscleroma.—Dr. SCHMIEDÉKE reports a case of this disease treated successfully by the local application of pyrogallic acid, and also makes an analysis of thirteen collected cases, five of which were in men and eight in women. An hereditary disposition to the disease is not manifest. In every case the isthmus faucium, the soft palate, and the uvula were ultimately involved, thus indicating a special proneness in the disease to invade the mucous membranes. The limits of age during which the disease appeared were 15 to 35 years, and in one instance only was a traumatic cause assigned to the disease by the patient. Of an exquisitely chronic nature, the affection begins with thickening and induration of the skin, generally in the cutaneous septum of the nose, or on the edge of one of the alæ nasi. Spreading from this point the disease alters in a very characteristic manner the contour of the nostrils. The alæ nasi are pressed outward to an extreme degree, while the tip of the nose approaches the upper lip, so that the appearance presented is that of a nose flattened out against the face. By reason of the growth of these hard masses from the alæ and septum of the nose, sooner or later entire occlusion of the nostrils takes place. The hardness of the parts admits of no approximation of the same, the whole nose being rigid as if carved in ivory. The changes in the upper lip consist usually of hard round plaques, with edges distinctly appreciable to the touch. The changes in the bones are slight, superficial excoriations at the most. Microscopical examination in the case reported showed epidermis thickened, but no striking change in the rete mucosum. In the true skin a dense infiltration of distinctly nucleated cells, about the size of a red blood corpuscle. In the deeper layers of the corium the infiltration was broken up by stout bands of connective tissue. The cross-sections of blood-vessels were sur-

rounded by a zone of crowded cells. The résumé of the pathological course of the disease is taken by the author from Mikulicz. Of the round cells which compose the infiltration, some are changed into spindle cells, and finally into connective tissue, which forms a network enclosing the remainder of the round cells. These latter remain for a time unchanged, but are finally disintegrated and destroyed, so that all that remains is contracting cicatricial tissue. It is by reason of the sluggish course of this destruction that rhinoscleroma are of such eminent stability. A spontaneous destruction of cells with accumulation of the products of disintegration does not occur. The change of the small round cells into spindle cells, and the formation of connective tissue, places the disease among the chronic inflammatory processes, and proves that it is not sarcomatous in nature, as assumed by Kaposi. The collected evidence is against any connection of the disease with syphilis. Internal treatment is useless, and local attacks upon the integrity of the tumor with knife and caustic is the only thing which holds out chance of success. In the case reported bits of the tumor were excised from the nostrils in order to give room for the insertion of plugs smeared with ung. pyrogallicum, one part of the acid to five of vaseline. These were renewed daily, and the result was encouraging; the patient, who at one time was much disfigured, at the end of four to five months of treatment, "presenting nothing remarkable in the nose."—*Vierteljahresschrift f. Derm. et Syph.*, vii Jahrg., 2 u. 3 Heft, p. 257.

(Recent literature reserved for want of space.)

II.

SYPHILIS AND VENEREAL DISEASES.

SYPHILIS OF THE NERVOUS SYSTEM.

W. R. BIRDSALL, M.D.

Syphilis and locomotor ataxy.—Dr. W. R. GOWERS, in an article on this important subject, in reviewing the literature, says: "Much attention has been lately directed to the existence of a causal relationship between syphilis and locomotor ataxy, and in Germany, especially, facts have been marshalled on each side of the discussion. The occasional obtrusive association of the two diseases did not escape the keen eye of Duchenne. 'Some ataxic patients,' he said, 'had suffered from constitutional syphilis; it was the only reasonable or apparent cause of the ataxy; but the causal relation is uncertain, for, apart from the special symptoms of syphilis at its different periods, the locomotor ataxy presented in these patients no new or special symptoms, and specific treatment, as a criterion, was equally useless.'

"No subsequent writer, with the exception of Schultze, attached any importance to the association until in 1876 Fournier (*Gaz. Méd.*, Paris, No. 53, 1876) insisted on its frequency. His experience that syphilis preceded ataxy in twenty-four out of thirty cases which had come under his notice, was generally regarded as due to the special character of his practice. So also with an association of the frequent relationship of the two made in this country by Drysdale. Vulpian, however, to whose sphere of observation the objection does not apply, stated in his lectures published in May, 1879, that 'there are actually few patients with locomotor ataxy who have not had, some years before the appearance of the first symptoms of this affection, an infecting chancre and secondary syphilitic accidents. * * * I do not think that it is an exaggeration to say that of twenty patients attacked with locomotor ataxia, there are at least fifteen who are old syphilitic subjects.' Attention was especially drawn to the subject by a paper by Erb, published in July, 1869, in which he stated that of 44 cases observed consecutively, there was a history of antecedent syphilis in twenty-seven, or 61 per cent. Statistics of a different character have been brought forward by German authorities whose opinions are entitled to great weight. Westphal, of seventy-five cases, found that 18½ per cent. had had primary sores only, and another 14½ per cent. had had secondary symptoms. E. Remak found a history of syphilis in only one quarter of fifty-two cases, and Bernhardt the same proportion in thirty-seven cases."

The author himself expressed the opinion, in 1879, that syphilis must be regarded as a cause of locomotor ataxy in one half of the cases of that disease. He now gives the following facts in support of this view.

Of thirty-three unselected cases, eighteen presented a clear history of constitutional syphilis; fifteen described both primary sore and secondary symptoms; three described the latter, but were ignorant of having had the former; five others had had a sore but no secondary symptoms; in the remaining ten cases there was no history of a sore or of constitutional symptoms. Thus, of thirty-three cases twenty-three (70 per cent.) had suffered either from a primary sore or secondary symptoms, and in 53 per cent. there had been undoubted constitutional symptoms. The facts also suggest that syphilis is an antecedent of ataxy at least as frequently in the well-to-do classes as among the poor. "If we deduct 20 per cent. as explicable by accidental coincidence, there will still remain 50 per cent. of the cases of ataxy in which we must regard the antecedent syphilis as the essential cause of the disease. It may not have been the only cause of the disease, but the teaching of these facts as far as they go, is that one half of the patients with ataxy would not have had this disease if they had not at some previous period suffered from syphilis."

His answer to the opponents of this view is that their statistics

were based on old notes of cases. "The lesions in locomotor ataxy are, however, very different from those which are ordinarily caused by syphilis." It is a degeneration limited to a system of structure, and contrasts with the random distribution of ordinary syphilitic processes. This objection has been urged with force by Broadbent, Jullience, Westphal, and others. I can corroborate the statement made by Westphal, that in cases which succeed syphilis the lesion is precisely similar to that found in other cases. But theoretical considerations of this character must yield to facts. We know too little of any morbid agency to limit its possible operation to certain forms of effect with which we may happen to be familiar. * * * The common failure of antisyphilitic treatment in ataxic cases, which Duchenne pointed out, has been confirmed by most subsequent writers, with the exception of Fournier. The failure of the therapeutic test cannot be held as invalidating other adequate evidence as to the causal relation of the two diseases. * * * I have seen one case of early ataxy in which iodide and mercury effected a practical cure. * * * It seems that one effect of constitutional syphilis may be to induce a neuropathic state in which certain degenerative diseases of the nervous system readily occur."

As a rule the interval between syphilis and the first symptoms of ataxy is considerable. In no case of simple tabes was it met with earlier than seven years after infection; two thirds of the cases occurred more than ten years after the primary disease. —*London Lancet*, 1881, i, p. 94.

Tabes and syphilis.—Prof. W. ERB, in a provisional communication, reports additional statistics on this subject. Though he was formerly inclined to deny the etiological connection between syphilis and tabes, the positive statements of the French authors (Fournier, Vulpien, and Grasset) incited him to undertake a more exact investigation of the subject, which exhibited to him extraordinarily startling figures. He objects to the widely different conclusions reached by his opponents, and states that he might possibly have reached similar results had he taken old clinical records, in which no especial attention was paid to the relation in question. He protests against the view that the facts of pathological anatomy can decide this question. The pathological anatomy of to-day appears to him entirely insufficient in this particular respecting tabes, as well as the changes attributed to late syphilis. "It has so much to learn itself, that it is impossible for it, as yet, to be our teacher." "Nor are we," he says, "sufficiently acquainted with the action of the syphilitic poison to assert with any certainty that syphilis cannot call forth a 'systematic disease' like tabes. The proof that tabes is a 'systematic disease' is still wanting; and in fact what kind of a 'system' must that be in which the optic and ocular nerves, the sensory nerves of the extremities, the vesical nerves, the coördinatory tracts, the pupillary fibres, and others as well, find their place? Who possesses that

coveted knowledge concerning the syphilitic poison which enables him to maintain: *this it cannot do?* If, however, tabes is truly a 'systematic disease,' it would appear, *a priori*, very plausible that it might result from syphilis; for it is known that certain systems of the central nervous organs act in a decidedly specific manner with different toxic agents. Why should not the syphilitic poison possibly have a particular relation to that system which possesses a predilection to disease in tabes? Really, all these considerations are as yet futile. It is only by more exact clinical analysis and statistics that the question can be reached."

Tabes and syphilis.—Prof. W. ERB, in a provisional communication, reports additional statistics on this subject. In 115 cases of tabes, which include 36 cases previously reported, he excludes 8 doubtful cases, and 4 in females. Taking 100 of these cases, in males, he gives the following statistics: Without previous syphilis or chancre, 12 per cent.; with previous syphilis or chancre, 88 per cent.; of these, with secondary syphilis, 59 per cent.; and with chancre, but without secondary symptoms, 29 per cent.; of the latter, 11 had had specific treatment, in 15 this point was not determined, and in 3 the chancre was designated as "soft." The percentage remains about the same for the large number as for the 36 cases first reported. The following is given respecting the time at which the first tabetic symptoms made their appearance after syphilitic infection: Before the 3d year, none; 3d to 5th year, in 17 cases; 6th to 10th year, in 37 cases; 11th to 15th year, in 21 cases; 16th to 20th year, in 3 cases; 21st to 25th year, in 5 cases; after the 31st year, in 2 cases; unknown, in 3 cases. In order to answer the objection repeatedly raised, that the frequency of syphilis was so great in the grades of society in which the observations were made that an accidental coincidence was possible, four hundred male patients, over 25 years of age, were taken, who were not affected with tabes nor directly with syphilitic disease, being mostly neurotic cases. Of these, 77 per cent had never been affected with chancre or secondary syphilis; 11 per cent. had had chancre, and 12 per cent. secondary syphilis. So that in the same grade of patients we have only 23 per cent. affected with syphilis to compare with 88 per cent. in tabetic patients. He concludes that these figures indicate very decidedly an etiological connection between syphilis and tabes, though he is far from asserting a positive conformation, and still farther from attempting in any way to formulate the facts more definitely at present.—*Centralblatt f. d. Med. Wissenschaft.*, Berlin, 1881, xix, pp. 195, 213.

On the characteristics of myelitis and tabes following syphilis.—M. ROSENTHAL considers it remarkable that the first production concerning this important question should have been from the statistical side, the results of which method could hardly have been otherwise than ambiguous. The author himself previously reported 65 cases of tabes, of which one only followed syphilis.

In the last two years he has observed in hospital and private practice 105 cases of tabes whose clinical histories were carefully examined; of these, 19 presented secondary syphilitic antecedents. This would make 12 per cent. syphilitic, if the original 65 cases were added; excluding these, and accepting the new cases only, the percentage is increased to 18 per cent. A greater proportion occurred among the inhabitants of cities than among those of the country. Females were rarely affected. In 10 out of the 12 cases the individuals were subjected to severe exposure to cold or fatigue soon after the completion of a "syphilitic cure." In 5 cases a long-continued "specific cure" was followed by aggravation of the tabetic affection. Tabes appeared in five other men, after several years, who had been treated for syphilis six to ten years before; and having been married after the disappearance of all symptoms, they became fathers to from one to three children who were born healthy and remained so. There is no justification for stamping these cases as specific. The author claims that the acceptance of the relations of syphilis to tabes will rest upon more or less doubtful variations according to the countries and the grades of society from which the clinical material is recruited, and also, to the reliability and purity of the etiological statements concerning infection or the causal factors. In consequence, the varying calculations from statistics cannot be accepted as a scientific basis for systematic demonstration. The anatomical and the clinical methods remain. After reviewing the pathological anatomy he concludes that "in the literature of the subject not a single case is to be found in which a *primary* degeneration of the posterior columns of the cord resulting from syphilis is demonstrable." Reference is made to Westphal's 16 autopsies of tabetic patients who had formerly had syphilis, in which respecting specifically diseased organs a negative result followed in 14 cases. In one case residua were found; while the remaining case was doubtful. He says: "As yet there is no anatomical basis for the specific origin of sclerosis of the posterior columns. Therapeutical results are as rare and incomplete in tabes following syphilis as in the common form. Positive cures are as yet mere assumptions, and are therefore doubted by Westphal and others with good reason." The author then considers the question from a clinical standpoint, giving the differential diagnosis between tabes and syphilitic myelitis. He concludes as follows: "These facts admonish us to be on our guard against optimistic conclusions which might easily be drawn from the syphilitic antecedents of tabes."—*Wien. Med. Presse*, xxii, p. 202, 1881.

Syphilis and degeneration of the posterior columns of the spinal cord.—In the report of a paper by Prof. WESTPHALL, on the above-named subject, and its discussion before the Berlin Med. Gesellschaft, the following statistics were given. From 97 cases of tabes, 22 were excluded on account of imperfect histories;

of the remaining 75, secondary syphilis had been present in 14 per cent., exclusively in males; sores, without secondary symptoms, in 18 per cent., also exclusively in males. In the 97 cases signs of secondary syphilis were found at the admission examination in only one male. In 16 autopsies of patients treated for tabes, 11 of which were males, in 9 cases nothing corresponding to syphilis was found. In one case residua were present; in one it was doubtful. Among the 5 female patients no changes of internal organs were found to indicate syphilis. He says: "These results do not speak in favor of etiological connection between syphilis and tabes dorsalis, nor do the results of treatment add much in its favor. Gray degeneration of the posterior columns has never been cured by antisyphilitic treatment."

A case of epileptiform convulsions of the right side, followed by death, was reported, in which a gumma was found in the posterior part of the corpus callosum, extending principally to the left, and redness of the cervical posterior columns only; the latter being partly in the columns of Goll and partly at the border of the outer portion of the posterior columns. The medullary sheath had disappeared, the axis-cylinders remaining. The interstitial connective tissue was not sclerosed, though there were distention of the blood-vessels and some thickening of their walls; thus differing from the usual gray degeneration. The author does not consider that this case supports the theory of the connection of syphilis and degeneration of the posterior columns. In the discussion Dr. Mendel referred to Virchow's statement, that it cannot be doubted that many cases of tabes dorsalis (gray atrophy) are syphilitic. Respecting the results of treatment, it must not be forgotten, he said, that it was often commenced at a time when it was too late to repair the injury done, and that the central nervous system offered greater obstacles to the treatment of specific disease than other organs. He referred to a case of syphilitic gray degeneration of the posterior columns reported by Berger as cured. Westphal, in reply, demanded very thorough proof concerning a single exceptional case, on account of the frequent errors in the diagnosis of tabes, and from the fact that cases of ataxia occur, which are rapidly curable. Gummata can, without question, be removed by antisyphilitic treatment, but not gray degeneration of the posterior columns. Dr. Rémak remarked that, when the recently claimed syphilitic etiology of tabes never came to the knowledge of Romberg and other good authors, and was not even recognized by Eulenberg, who found in 149 cases only one attributable to syphilis, may it not be asked if it is not, after all, as is so frequently the case in pathology, a sort of fashion mania. In 52 cases of tabes seen by him during the past four years (47 male, 5 female), he places 25 per cent. as the proportion syphilitic; somewhat higher than Westphal's, and even Berger's, who reported 20 per cent. in 145 cases. Rémak's cases were from out-patients in the working class. He advises caution in pushing antisyphilitic treatment in such cases, for fear of aggravating the tabetic symp-

toms. Dr. Bernhardt thought that all these statistics ought to be reviewed to see whether syphilis alone or still other etiological factors had been present or not, such as chilling, wetting, fatigue, and excess in venery. In 67 cases of tabes (58 male, 9 female): of the females he found in no case evidence of former syphilis; in 7, however, sufficient etiological factors were determined, such as exposure to cold, wet, and draft. Of 37 males in which exact histories were obtained, 22 denied syphilis absolutely; 7 had had gonorrhœa or sores, but no secondary symptoms; while 8 acknowledged having had syphilis.—*Berlin. Klin. Wochenschrift*, Nos. 10, 11, 1880.

On syphilitic epilepsy.—Among the numerous important and interesting topics discussed by Dr. M. G. ECHEVERREA in an article of thirty-six pages, the question whether there is a secondary and tertiary epilepsy distinct from each other, as held by Fournier, is considered at length. He concludes that precocity in the evolution of epilepsy depends on the nervous predisposition of the patient rather than on the condition connected with the stages of the syphilitic diathesis itself.

If the nervous system is in any way impaired in its activity, and through disturbing nutritive agencies set up by accidental organic derangements does not keep within the normal standard, syphilis will operate simultaneously with such agencies to favor, with strange rapidity, the evolution of epilepsy or any other nervous disorder. In 118 cases, epilepsy appeared most frequently from the first to the second year. He does not accept Fournier's opinion, that, because the attack during the secondary stage may explode and disappear, simultaneously, with the eruption of the specific accidents, the epileptic phenomena are not connected with material lesions of the nerve centres, and cites cases to support his opinion. In a review of the pathological anatomy of nervous lesions he makes the statement that there is a proportion of cases, not exceptional, in which the nutritive histological changes effected by syphilis primarily arise in the nervous elements themselves, without impairing the vascular or interstitial structures of the nervous centres. Two cases with autopsies are reported as belonging to this class, and the author adds that "the fact that syphilis is often a cause of locomotor ataxia determining a primary sclerosis strengthens the diagnostic views.—*Jour. Ment. Sci.*, London, 1880, n. s. xxvi, p. 165.

In the first of these cases which accompany this dogmatical remark on this unsettled question the lesion found was a "symmetrical and primitive sclerosis of the lateral columns in the dorsal region." How such a case can be quoted as illustrative of a lesion "without impairment of the vascular and interstitial structures of the nervous centres," sclerosis being pre-eminently a condition in which these tissues are involved, it is difficult to understand, nor is the case at all conclusive in showing that the lesion found was due to syphilis. The second case

is equally unsatisfactory in showing that the lesions found were due directly to syphilis.—*Rep.*

Case of gummata in brain, liver, and testicles ; autopsy.—Dr. BRADBURY reported at the Cambridge Medical Society the case of a male, *æt.* 30, who, eight months before admission, had pain in the left arm and shoulder, loss of power in left arm and hand. Disappearance of pain under treatment in two weeks ; three months later, pain in the right supra- and infra-orbital regions ; gradual loss of sensation over the whole right side of the face, with increasing pain. A month before admission, squinting of the right eye ; “flashiness” before the eyes two or three times a day ; swelling of the testicles, without pain ; loss of taste on the right side of the tongue. On admission, marked internal strabismus was observed ; also a degree of ptosis, slight ; left deviation of the tongue ; almost tonic spasm of the levator muscles of the angle of the mouth ; a few days later, congestion of the right conjunctival vessels, followed by a conical ulcer which healed ; later, just before death, another attack with sloughing of the conical cicatrice ; variations in facial pain and spasm of facial muscles ; slight left facial paralysis ; involuntary evacuations ; marked loss of strength ; general tremors of body ; constant twitching of lower lip ; speech almost unintelligible ; complete paralysis of left hand just before death. Treatment by calomel and potassium iodide. The autopsy revealed the tunica vaginalis on both sides distended with fluid ; gummatous nodules, two in each testis ; interstitial orchitis ; gummatous nodules in the left lobe of the liver. Within the cranium, attached to the dura mater, making a depression on the surface of the brain about the centre of the right ascending parietal convolution, was a firm, circular, flat gummatous body, the size of a horse bean. On the pons Varolii, involving the roots of the right fifth and sixth nerves, and overlapping the origin of the seventh, was another flattened gummatous mass. Another gumma was found on the upper surface of the cerebellum, in the middle line anteriorly, in the membranes, not involving the substance. A semitransparent gelatinous substance, with an opaque yellow centre, the size of a walnut, was found in the left occipital lobe near the surface. The right corpus striatum and optic thalamus were softened.—*Brit. Med. Jour.*, 1880, ii, p. 17.

On the structure of gummatous new formations in the tissue of the brain.—Dr. W. BECHTEREN reports two cases under the above heading, with autopsies and an analysis of the histological examinations. He does not accept the theory of Charcot and Gombault concerning the development of the star cells (*sternzellen*) out of normal neuroglia tissue, but considers that the “granulation-cell” (white blood-corpuscle) plays an important rôle in their production.—*St. Petersburger Med. Wochenschrift*, 1880, No. 26, p. 215.

SYPHILIS OF THE MOUTH, THROAT, AND LARYNX.

D. BRYSON DELAVAN, M.D.

Resection of the larynx for laryngeal stenosis.—BRUNS' article refers to the most severe forms of laryngeal stenosis, the so-called cylindrical strictures, in which the stenosis is very narrow and at the same time extends over the greater part of or even the entire larynx. Although in severe cases gradual dilatation by Schrötter's process may be so far accomplished that when the canula is closed, breathing through it is possible, still this treatment must be considered as very tedious. Bruns wishes, therefore, to confine the treatment by dilatation to the comparatively mild forms of tubular stenosis. In severe cases, where the cartilaginous structure is still preserved, laryngotomy should be performed. A laryngeal canula must be introduced beforehand, over which cicatrization of the wound takes place, while respiration through the mouth is re-established. If the cartilaginous structure be already broken up by necrosis, then Heine's subperichondral resection is advisable, in order to make the introduction of a tube possible. The best form of canula was found to be that of the author, made after the style of Richet's. To the vertical piece of pipe an apparatus can be attached for the practice of speaking. This annex carries at its upper end two india-rubber membranes by which the produced voice acquires a greater resemblance to the human one. There is also a mechanism in the canula which allows only the inspired air to pass through the outer opening, while the expired air has to escape through the phonation tube. As soon as the wound is healed and the laryngeal canal is consolidated, a tube more comfortable to the patient is applied. In the first place a tracheal tube connected with a cervical plate is introduced, and then through an opening in the anterior wall of the same a laryngeal tube is passed in. With this arrangement it is easier to introduce, according to need, either the respiration tube or the phonation canula. The objections to this treatment are 1st, loss of phonation; 2d, the use of the canula, which prevents an entire healing of the parts. It must be remembered, however, that in those cases where the operation had been resorted to, the voice had already been lost for some time.—*Berlin. Klin. Woch.*, 1880, Nos. 38, 39; *London Med. Record*, May 15, 1881.

A rare case of laryngeal stenosis.—HEINZE reports a case of laryngeal stenosis in which ulceration of syphilitic origin was followed by adhesion of the epiglottis to the posterior wall of the pharynx. This condition was relieved by repeated applications of the galvano-cautery. During the third application such severe hemorrhage was produced that it became necessary to ligate the external carotid artery. *Wiener Med. Presse*, No. 44, 1880.

Syphilitic stricture of the pharynx.—In reporting the history of a case treated by himself LANGREUTER has collected all the cases of this lesion which have been published during the last

fifteen years. The contraction and displacement in his own patient were unusual. The plan of treatment adopted was the internal administration of antisyphilitic remedies, together with local surgical measures. A good résumé of the results of operation in the above cases is given, together with some important deductions therefrom.—*Deutsch. Archiv. für Klin. Med.*, November 18, 1880.

A study of secondary syphilitic laryngitis.—BOUCHEREAU's thesis embodies the result of his researches upon the above subject in the hospital wards of Dr. Gougenheim.

The author considers a laryngoscopic examination indispensable in revealing the existence of syphilitic laryngitis, as in many cases functional disturbance of the organ is wanting. Of 135 cases of secondary syphilis 59 showed laryngeal complication. Considerable space is devoted to the history of the subject. The presence of mucous patches in the larynx, admitted upon hypothesis by Trousseau and Belloc, was first proved by Czermak in 1860. In 1866 Turck described a catarrhal syphilitic laryngitis. Dana, in 1864, gave a history of a case of roseola of the larynx, which resembled in all respects a cutaneous roseola with which it was coincident. He described also papular and tubercular eruptions analogous to the cutaneous syphilides of the same name. Fournier has called attention to the rarity of functional disturbance of the larynx in secondary syphilis, and the much greater frequency of these complications in the male than in the female. Mucous patch of the larynx has been well studied by Krishaber and Mauriac. According to their observation, it is most frequently found upon the true vocal cords. Bouchereau found it most frequently on the epiglottis.

In chapter 3 is given the statistics and the classification of the observed lesions. These are divided into : 1st, general lesions ; 2d, local lesions. The first, which were found in 24 out of 59 cases, consist in a more or less intense hyperæmia. Circumscribed lesions are more frequent : in 8 patients there was a simple localized hyperæmia ; in 7 others, the same lesion with considerable swelling. In 20 other cases there were found mucous patches, located most often upon the epiglottis. The symptomatology of the different lesions is variable. Where redness exists it is deep and carmine, sometimes almost violet, contrasting with the pallor of the neighboring mucous membrane. The epithelium disappears, and upon the free border of the epiglottis small fissures appear. In a more advanced period these fissures give place to true linear ulcerations. Dysphagia and dyspnœa are rare, and cough is moderate. The whole laryngeal symptoms last about one month. The mucous patches are developed in about six weeks. Intense inflammations of the pharynx and buccal cavity, such as mercurial stomatitis or erysipelas, may exert a favorable influence upon the progress of these lesions. The prognosis of the laryngitis of secondary syphilis is good. It is only affected by frequency of re-

lapse and by the functional modifications of which it may be the consequence. As to treatment the author recommends the internal administration of specifics, and applications to the larynx of a solution of nitrate of silver, 10 to 20 grains to the ounce. The thesis is illustrated by several chromo-lithographic figures.—*Thèse de Paris*, 1880.

Notes on syphilitic stricture of the larynx: two cases operated upon by means of a new cutting dilator.—WHISTLER reports two cases which are possessed of especial interest as demonstrating the value of a new method of treatment devised by himself. Case 1 was one of tertiary syphilitic ulceration of the pharynx, followed by perichondritis and ulceration of the larynx, with stenosis from adhesion between the ventricular bands. In case 2, cicatricial adhesion between the vocal cords followed tertiary ulceration of the larynx.

In order to meet the requirements of these cases the author devised an instrument intended to combine the properties of a knife and a dilator in one. This laryngotome is composed of an almond-shaped dilator, within which is a concealed blade. The blade is reversible, so that it can divide a stricture either at the anterior or posterior commissure of the larynx, and it can be pushed forward, when required, by means of a lever attached to the handle. The principle is that of the dilating urethrotome.

The author gives an excellent résumé of the literature of the subject, and concludes that, as regards the tertiary affections where dilatation is essential to overcome the laryngeal obstruction, the ultimate result of this operation must depend in a great measure upon the stage which the affection has reached. He classifies the lesions under two main divisions: the acute and the chronic stages of the tertiary period. The former include gummatous growths, either tumors or, far more often, softened gummata with consequent ulceration. Successful dilatation of the larynx may be regarded as probable in acute gummatous inflammation and in relapsing laryngitis of the tertiary period. In the more chronic cases, where fibrous growth is out of all proportion in excess of the morbid processes, tracheotomy is, as a rule, imperative, and little benefit can be expected from dilatation. Finally, the author, dwells upon two practical and highly important points in these cases as having a direct influence upon a successful result: 1st, early tracheotomy to decarbonize the blood and admit of reparative change, as well as to avoid pulmonary irritation; 2d, early subsequent efforts at dilatation to prevent those morbid processes which may arise locally from pressure of the tube or by extension in the lungs, at the same time guarding against a too early withdrawal of the tracheal tube.—*Archives of Laryngology*, vol. i, No. 4, and vol. ii, No. 1.

The value of local treatment in syphilitic ulceration of the larynx and pharynx.—ARNOLD labors to prove a fact long ago established, that in syphilitic ulceration of the larynx and

pharynx local treatment is of decided value. The method advocated is first, thorough cleansing of the parts by means of a weak solution of sulphate of copper; then application of nitrate of silver, fused upon a probe, to the infiltrated edge of the ulcer; and, finally, application, by means of the brush, of a strong solution of iodine in glycerine *two or three times daily*. Meanwhile constitutional measures should be employed.—*Maryland Med. Journ.*, May 15, 1881.

Congenital syphilis of the throat.—MACKENZIE'S elaborate paper is one of the most valuable contributions made to the literature of laryngology during the past year. Its aim is to call attention to the throat as a frequent seat of the lesions of congenital syphilis. It is based upon a careful study of about 150 cases of congenital syphilis of the throat personally observed, together with all cases available in the literature of the subject. The larynx may be involved at any period. Monti states that he has seen two cases of laryngeal syphilis which arose during intra-uterine life. The most common period of invasion is the first six months after birth. The ulceration may occur in any situation, but its favorite seat is the palate, and especially the hard palate. The next most frequent localities are, in order of frequency, the fauces, naso-pharynx, the posterior pharyngeal wall, the nasal fossæ, the septum nasi, the tongue, and finally the gums. A peculiarity of these ulcerations is their centrality of position, and their special tendency to attack the bones and eventuate in caries and necrosis.

The prognosis is influenced by the age of the patient. The earlier the throat is attacked, the more serious the results. Pharyngo-laryngeal ulceration occurring during the first year is almost always fatal. Deep ulceration of the larynx is serious at any period. Pharyngeal ulceration appearing late, or, as a manifestation of tardy syphilis, yields to iodide of potassium. The prognosis in chronic superficial laryngitis is more favorable as regards life, although the tendency to laryngeal spasm and œdema should be remembered. In acute laryngeal syphilis the treatment should consist in mercurial inunction over the thyroid, the inhalation of calomel or iodate of zinc in the form of vapor, and the internal administration of potassium iodide in large aggregate doses, pushed rapidly to the verge of iodism. Should the inflammation not yield within 48 hours, or should it show a tendency to advance, the trachea should be opened. In the more chronic forms, mercury in tonic doses, combined with iodide of potassium, should be exhibited, the local treatment consisting in the use of stimulating pigments and inhalations. As topical applications to the pharyngeal ulcerations, great reliance may be placed upon iodoform or the vapor of iodate of zinc.—*American Journ. Med. Sciences*, Oct., 1880.

(Recent literature reserved for want of space.)

ARCHIVES OF DERMATOLOGY

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Original Communications

THE LIMITATIONS OF INTERNAL THERAPEUTICS IN SKIN DISEASES.*

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I WOULD like to approach the consideration of this question from a purely empirical standpoint, uninfluenced by theories and traditions, and supported only by the results of observations made and recorded in ways recognized as strictly scientific, although fully conscious that etiology and pathology, were our knowledge sufficiently advanced, should form the groundwork of rational discussion of the subject. Cutaneous pathology offers in fact an exceptional field for studying the action of drugs introduced through the stomach, for not only are all the means ordinarily availed of in judging their effect in general diseases at the service of the dermatologist, he has also the opportunity of watching directly the phenomena of tissue change or modification of function he is aiming to effect. The most marked progress in the management of certain regional diseases has resulted from the success of modern skill in creating similar favorable opportunities for direct observation and local treatment through the use of the laryngoscope, rhinoscope, ophthalmoscope, endoscope, etc. And yet, with all this advantage, who would venture to claim that

* Read at the meeting of the American Dermatological Association, September, 1881.

internal therapeutics in cutaneous disease is in any degree more fixed in its system, or satisfactory in its results, than in general medicine? This is not due to lack of enterprise certainly, for it may truly be claimed that both in historic and modern medicine, every drug known to science has been freely administered in the treatment of skin diseases. Novelties in this, as in all departments of therapeutics, have appeared thickly along the course of the past centuries, have worked their marvellous cures, have been awarded even the saintly title *specificum*, and have been forgotten. Some have been revived for brief periods to sink finally into oblivion. Some have survived to the present day in restricted centres, remnants of barbaric medicine, saved through superstition, patriotism, or loyalty to inherited theory. Some, a very few, have secured and retain a universal and well-proved reputation as serviceable agents in limited fields of usefulness. The vast and varied materia medica, then, of the past and present, has by elimination reduced itself to a very few substances, which are universally recognized as of some service in the treatment of skin diseases when administered internally, and to a somewhat larger class, constantly changing, which enjoy with individual dermatologists or with national schools the reputation of active and important agents, while by others they are regarded as completely worthless. These differences of belief, by no means confined to the practice of dermatology, furnish the illustration of the difficulty first alluded to: the impossibility of coming to any fixed and definite doctrine of general therapeutics in the face of all these conflicting views of individual writers and schools. We see the optimist ready to believe good of all the articles of the materia medica, forced indeed by the very universalism of this confidence to be constantly putting aside the old for the latest new remedies; we see the most conservative and experienced master making acknowledgment late in life that his scepticism with regard to the action of certain drugs was erroneous. One school expresses a sure belief in the great importance of some simple herb in a great class of disorders, while their rivals across some geographical boundary line ridicule such

simplicity. A most respected author states that there is no more reliable remedy in certain infantile dermatoses than some drug, which another distinguished dermatologist reports after prolonged trial to be valueless.

Allowing for all possible variations in the action of these drugs, in the character of the disease, or the constitution of the patient, due to geographical or race differences, the chief cause of such diversity of opinion must be improper methods of experimentation or observation employed, or the unscientific or unreliable conclusions of the observers. So contradictory, so unsatisfactory must the therapeutics of our branch of medicine remain, until better methods of study are adopted and the faults of individualism eradicated from it. These elements of error,—the bias of early teachings, prejudices against particular schools, subserviency to mere theorizing with regard to the necessity of internal medication, either popular or professional in its origin, an *a priori* scepticism which refuses all personal investigation, hasty generalizations from inconsequent or too meagre data,—can, in my opinion, be eliminated only by a systematic plan of experimentation conducted by no one person, but by a committee of competent observers fairly selected.

It would not be boastful to say that nowhere does there exist a body of dermatologists so broadly cosmopolitan in spirit and training, and representing such varied opportunities of research as are afforded by wide differences in climate and race, or one more competent for such work, than the gentlemen who compose the American Dermatological Association. Let us suppose that such a committee were organized, what should be its scope, what its methods of work? A member presents a paper upon the specific effect of some drug in this or that affection, or upon the action of some class of remedies in certain pathological changes of the skin, or upon the properties of some new remedy. Ordinarily his conclusions would be supplemented by the expression of the views of others more or less positive in support or negative in opposition. If the matter were novel, criticism would be little else than theorizing, and there the subject would generally rest. There would

be very little enquiry as to the extent of the data or the accuracy of the methods upon which the conclusions offered by the writer were based, but little action here which would stamp the communication as of more exact value to medicine than had it been published simply in journal form. By such treatment the society fails to fulfil one of its highest duties to the profession in general, in allowing any thing to receive its apparent sanction which shall add to the present inexactitude of cutaneous therapeutics, and in proper appreciation of the author's labors, who should court the investigation of an impartial and expert enquiry, knowing that in this way would their merits be most freely accepted by the medical public. In this way, too, the society would do much to discourage the loose writing and the claims based on insufficient observation, which generally herald the introduction of each new remedy. One would hardly venture to announce here a novelty in therapeutics, unless the discovery were based upon methods of investigation employed by such a committee in subsequently testing its value. To it might be referred not only all appropriate communications presented to the association, but all doubtful questions of importance in therapeutics, which now vex us so frequently, of old or new origin.

I will cite a few which suggest themselves to me by way of illustration.

The action, beneficial or injurious, of our most celebrated springs in affections of the skin. A report upon this important subject would do much to clear away the atmosphere of charlatanism which has hitherto obscured it, and develop some knowledge of certain character regarding it which the profession of this country has so long needed.

The power of electricity over the so-called neuroses of the skin (including zoster).

To what extent may certain substances in common use be applied to the skin without danger, viz.: compounds of zinc, lead, mercury, carbolic acid, etc.

Such would naturally be the scope of the committee's labors; the methods employed would be of necessity limited in some respects. Unfortunately we have in this country

few hospital wards devoted to the care of skin diseases, where, under the observation of competent dermatologists, the action of remedies may be properly studied. Our conclusions must be formed almost wholly from the voluntary visits of out-patients, whose conduct between the same is entirely without our knowledge, and from the almost as unsatisfactory class of private patients who come to our offices. In both, the character of the drugs, the amount and frequency of administration, the regulation of counteracting influences, and other conditions essential to reliable investigation, are not under our direct control. It is by the number rather than the quality of our observations that we now arrive at any definite information. Still, with such opportunities at our command, we may do much in promotion of this object. The committee would hardly be satisfied, however, with a collection alone of loose opinions already formed upon such data in their investigation of any question, interesting as such information would be, as they would be merely balancing conclusions from many observers, formed, it may be, under conditions quite dissimilar and irreconcilable even with the accompanying information of the methods of research employed. The committee would naturally formulate a series of questions covering the whole ground, so framed that at least all error from inexact or insufficient observation would be excluded. The results thus obtained, after presentation in proper form to the association for discussion, would eventually go out to the world with an authority which would command credence everywhere. Such a plan is in no way impractical, although as yet unattempted. This association should not hesitate to demonstrate its ability to execute it.

I think that nothing would more easily convince members of the necessity of taking some immediate step toward placing the study of internal therapeutics in our specialty upon a scientific and progressive basis, than to read over in connection the brief chapter with this heading in every modern publication on general dermatology. I do not so much refer to the differences of opinion they contain, but to the almost total absence of fixed knowledge upon which

any generalizations may be based, and without which, of course, such differences of opinion are inevitable. It may not be inappropriate to attempt to expose here in concise form the meagreness of such knowledge. It may perhaps be best expressed in the form of an analysis of the limitations of our control over the different pathological processes which constitute our general divisions of individual diseases.

1. *Affections of the Glands.*—We have here included a group of disorders caused by increased, diminished, modified, or retained secretions. How far is it possible to influence the functions or mechanical processes of these glands by the internal use of drugs? We can stimulate the general cutaneous circulation, and thereby produce a free perspiration; we can awaken the sweat glands to excessive activity by *jaborandi*; we can create also a dryness of the skin by dangerous doses of well-known substances, but we are unable in this way to permanently relieve the habitual conditions of hyperidrosis or anidrosis, or by other means to alter the quality of the perspiration, so far as its color or odor is concerned. Our power over the action of the sebaceous glands is even more limited. I have seen it stated that the free use of certain oils will increase the amount or fluidity of the sebum excreted; I am unable to say from experience how correctly, but I doubt if any article of the *materia medica* can be put into the circulation capable of directly correcting a seborrhœa or removing the minutest comedo. That a milium or wen has not been resolved in this way goes without saying. That the sluggish action of the glands, associated with a chlorotic habit, may be to some extent indirectly influenced by ferruginous and other tonics, is not improbable.

2. *Inflammations.*—In connection with the great group of diverse affections exhibiting in common the pathological phenomena of the cutaneous tissues we call inflammations, the first question which should naturally suggest itself is: What agents have we capable of addressing themselves to this condition as such, directly or specifically? Have we such as are able to reduce or divert the cutaneous hyperæmia locally or universally? In the most acute types of cutane-

ous inflammation, of which the erythemata and some stages of eczema are marked examples, I have made thorough trial of such internal remedies as are claimed to act immediately upon it, as the acetates, citrates, and sulphates of the alkalies. I am not prepared to say to what extent I believe that they may affect this condition, or, if at all, in what way. I am willing to admit them as possible adjuvants of limited power. But among all the other articles of the materia medica which enjoy the reputation of being antiphlogistic, upon whatever theory it may be based, I know none capable of exerting such influence upon simple cutaneous inflammations. But in the great bulk of clinical features pathognomonic of this numerous group of diseases, we have to deal with many other conditions besides simple inflammation; its sequelæ and accompanying tissue changes are manifold. The remedies found in fact most serviceable in the treatment of these affections might be of direct injury in their most inflammatory stages. But the number of these of assured efficacy is very small. *Facile princeps* is arsenic. Yet nothing illustrates more forcibly the paucity of our internal remedies in skin diseases than the universal rôle of sole specific which this substance fills. There is scarcely any affection in which it is not given by the profession with routine constancy. Its powers, however, are unfortunately very limited. For outside of this group it may be said to be powerless, while within it its action is positively injurious in the most inflammatory states of the skin, and of real service only in a very small proportion of the affections included in it. When I mention psoriasis, chronic eczema, lichen ruber, and pemphigus, I have named all of them in which we can confidently rely upon it in any great measure. Even in these we know how often it utterly fails to accomplish what we expect of it, and how impossible it is to predict in any individual case, however favorable apparently, the measure or rapidity of its success. Upon the permanency of its influence in the recurrent forms of these diseases we cannot depend. There may be other members of this family in which arsenic is claimed to be of service, but the evidence of such belief is unsatisfactory.

But looking beyond arsenic what do we find upon which we can rely for aid in the management of this group? Tar and carbolic acid have been recommended by acknowledged authority in psoriasis, but they have not given general satisfaction and are little used. Iron and cod-liver oil are no doubt of moderate service, in some of the chronic affections especially, but usually only so far as their support is demanded by the general condition of the patient in individual cases. That they have any direct, specific action on the pathological condition of the cutaneous tissues I have seen no evidence. As to the antagonistic power of these and numerous other drugs over imaginary and undemonstrated conditions of the system in general, its fluids, functions, or organs, which play with some an important rôle in the etiology of these diseases, I will say nothing here. I am willing to acknowledge every success in therapeutics, on whatever theory it may be based, only the results must be real and demonstrated. It would be as easy and logical to argue back from the failure of such drugs to cure these affections independently and uniformly: that the latter can be in no way connected with such etiological conditions of the economy, as to draw opposite conclusions from their occasional usefulness.

3. *Hemorrhages*. Without attempting to define the questionable relations of hemorrhage into the cutaneous tissues to the dermatoses, or to explain the method of their existence, we may claim that we can control it in some measure by the internal use of the persalts of iron, by ergot, and other styptics.

4. *Hypertrophies*.—Is there any one disposed to claim that he can by internal medication control in the slightest degree any hypertrophy of the cutaneous tissues, from the most superficial keratosis to morbus Herculeus? Some of the incidental conditions connected with these affections, causative, it may be, or secondary, may be in some measure thus influenced, but not an established hyperplasy by a single cell, not a minute wart more than a Pfundnase.

5. *Atrophies*.—So too with the atrophies. We have not the power to restore a single pigment cell in leucoderma or canities by such means, or to add a new hair in alopecia.

6. *New growths*.—I doubt if there is any one so enthusiastic in drugs as to claim for them any influence over the development of the new-growths of the connective tissue, of the angiomata, sarcoma, or carcinoma. In lupus disease, the scrofulodermata, and syphilodermata we are by no means so powerless. In iodine we possess the means of restoring a healthy, conservative action in the most advanced tissue changes in the last two groups of diseases, although its efficacy may be restricted to their local and immediate manifestations. In lupus its beneficent effect is doubtful and very limited. In the syphilodermata we find our type of specific therapeutic action in the effect of mercury: an agent which works surely and uniformly, and, in large measure, thoroughly. It may all the more be regarded as possessing specific action, because in all other diseases of the skin it has little, if any power. In leprosy, several new remedies have been lately employed, but there is no evidence extensive enough at present to warrant a more favorable prognosis, either in respect to mortality or duration of the disease, than in past centuries.

7. *Ulcers*.—For ulcers as such we have no internal remedies of special application, although as advanced expressions of a depraved condition of the tissues they may be often benefited by many.

8. *Neuroses*.—I know no internal means of relieving the forms of anæsthesia and hyperaesthesia included in our restricted definition of the neuroses, whether of reflex or local origin, excepting those which temporarily blunt the sensorium to the fact of their existence.

9. *Parasitic Affections*.—Of the parasitic affections it may be safely said that, however much some may insist upon the importance of internal treatment in their management, there was never an instance of the cure of one of them by such means. When it can be shown that an itch insect or a louse has been slaughtered, or a single spore made unproductive by turning parasitocides into the stomach of the host, the importance of this channel of attack will be evident.

The number of individual affections of the skin recognized by us approaches closely one hundred. How many of these

are under the direct control of internal medication in any uniform or marked degree? I wish that I might claim such power over ten of them; such power as arsenic may exhibit in psoriasis, as mercury almost always does in syphilis, and which makes external treatment unnecessary. Even in respect to these exceptionally effective drugs, arsenic, mercury, and iodine, it cannot be said that they may not largely do their work upon the cutaneous tissues by direct local influence in the dermal circulation.

In this brief muster of the slim forces, which constitute our only reliable resources of internal medication in skin diseases, pessimistic as such a catalogue may seem to the sanguine practitioner, I have of course not intended to deny that much may often be done to hasten their good work by the simultaneous use of remedies which elevate the general tone of the patient's functions and tissues when needed, and the same is true of their action in many cases where we rely wholly upon local treatment for cure; but it would be impossible even to enumerate them here, as we are not discussing general therapeutics. There are innumerable coincident conditions associated with the dermatoses which may influence their progress, although they have no direct etiological connection with them, and which demand our attention. In other words, we have always our whole patient to consider. I do not, however, believe that these narrow limitations may not be enlarged, and I would encourage any experimental studies, empirical or philosophical, in this direction. It is the manner in which this important subject has been hitherto so generally treated, so detrimental to scientific progress, that I deprecate. But a frank confession of our present inabilities is an essential step in any real advance.

ON THE CAUSES OF ALOPECIA AREATA.*

BY DR. ROBERT LIVEING, LONDON, ENG.

I N bringing before you the subject of alopecia areata, and in trying to disprove the parasitic origin of the disease, I am aware that I lay myself open to the charge of an attempt "to slay the slain." A reference, however, to many writers on this subject will satisfy any one that a belief in the parasitic nature of the disease is still widely entertained. I shall, therefore, without further apology, apply myself to the subject.

I purpose to say but little on the fungus theory directly, but rather to attack it indirectly. In short, the theme of my paper is—*that the clinical features of the disease, alopecia areata, cannot be explained on the parasitic hypothesis.*

I. As to positive evidence. Ever since Gruby described, in 1843, a microscopic fungus in area, there have always been able supporters of the parasitic theory. The late Dr. Bazin was for many years its most powerful exponent, and he carefully describes and figures the microscopic appearance of the hairs affected; but while he supports generally Gruby's views, he gives a totally different description of the fungus, and at the same time draws a distinction between two varieties of the disease, both parasitic. Comparing the fungus with that of tinea tonsurans, the mycelium is *more abundant*, and with this his plates exactly correspond. Contrast this description with that of a distinguished and more recent observer, Professor Malassez. He says that the spores, some of which are nearly as large as those of the

*Transactions of the International Medical Congress, London, August, 1881.

trichophyton, are found abundantly in the epidermis, as well as in the hairs, but that there is a *complete absence* of mycelium. I will not extend my remarks on this point.

I have referred very briefly to the history of the observations of three representative men, and you will notice that they do not agree even on the most essential points.

Next, as to negative evidence—it is almost overwhelming. Many competent observers in Europe and America have searched, but searched in vain, for a microscopic fungus. We must remember, however, that *negative evidence* counts for little in comparison with positive statement; and as it is impossible to deny great ability to those who have been advocates of the parasitic hypothesis, it may be well to refer to a possible source of error. In 1870 I recorded the occasional occurrence of perfectly smooth, bald patches in tinea tonsurans, *exactly* resembling those of common alopecia areata,¹ and a little later I offered this fact as an explanation of some of the mistakes that had arisen. Quite lately, Eichhorst has found abundance of spores in *one case out of nine* very carefully examined, and I have little doubt that this ninth case was really one of bald tinea tonsurans. I would remark, in passing, that when in common tinea tonsurans one patch becomes quite bald, the others quickly follow suit.

II. I pass now to the second, and main part of my subject, in which I shall endeavor to show that alopecia areata is a disease of nutrition, the result of faulty innervation; and that the clinical characters of the disease cannot be explained on the parasitic hypothesis.

I. Let me briefly refer to the constitution of those who are liable to it. We know that it may occur at almost any age, and that it is rather more common in the young than in the old. It is probably more common also in persons of nervous temperament than in others, but on this I do not wish to lay any stress. There are, however, two points of importance to which I would draw especial attention: first, its great tendency to recur; and secondly, its slight, yet notable disposition to appear in different mem-

¹ First edition of "Notes on the Treatment of Skin Diseases," and more fully in the third edition.

bers of the same family. The former fact has been but little dwelt upon by writers, and yet I should say that it was one of the most constant features of the disease. A second attack is very common, and I have met with patients suffering from their fourth or fifth attack, with considerable intervals of complete unanimity.

Our President, Mr. Erasmus Wilson, has recorded several cases of very frequent recurrence of this disease; but it is not necessary to quote cases; the point will be conceded by all who have had opportunity of seeing many examples of the malady. This would surely indicate the existence of a constitutional tendency to the disease, which is confirmed by the fact that there is an undoubted hereditary disposition to area in some families.

2. I shall next ask your attention to the various local forms of functional nerve disturbance, which often precede or follow the loss of hair. It is now about eight years since my attention was first called to an example of almost complete insensibility of the skin over patches of area in a young lady, the daughter of a medical man, and since that time I have met with many similar cases, in which the sensibility of the skin has been, for a short time, lost, or very much impaired. Only quite lately I have had under my care a lady, about thirty, who is suffering from a second attack of almost complete alopecia areata of the scalp. I have still under my occasional observation a middle-aged man who was in the Middlesex Hospital, with three large patches of area, associated with complete loss of sensibility, which lasted for several weeks. The hair has now grown perfectly over all three patches; on one it remains white, while on the other two it has resumed its natural red color.

I would make one observation with regard to almost all the cases of loss of sensibility that I have met with, and it is this, that it appears as a very early and temporary symptom, and is *not* usually present in those cases which are attended with atrophy of the skin, in which one might have expected to find it; in short, what I refer to is a functional disturbance, passing away long before the hair is restored. A more common nervous symptom is that of neuralgia and

nervous headache, or a sense of tenderness of the skin on being touched; but all these subjective symptoms often disappear quickly, though the trophic nerves do not readily resume their proper functions.

3. The action of blistering fluids on patches of area is instructive. It often happens that fluid quite strong enough to blister other parts of the scalp will not produce a blister on the spot of area. I have noticed this so often that I am sure that it is not a very rare phenomenon. It certainly points to a low state of nervous vitality in the part affected.

4. With regard to the regions especially to be attacked, we meet with examples of alopecia areata of every degree of severity, from a single bald patch on the head to a complete loss of every hair on the body. Now, whatever we may hold with regard to a bald spot on the scalp, it is very difficult to believe that these latter cases, in which the shedding of hair is often very rapid, can be produced by a vegetable parasite, which, according to analogy, should spread by slow and gradual growth. I would remark, in passing, that true leprosy, a constitutional disease, will occasionally completely strip the body of hair, as we know it commonly does the face.

Again, the special liability of area to affect the lower occipital, and the regions behind the ears, and the outer portion of the eyebrows rather than, or before, the inner portion, is at least unlike anything we see in *tinea tonsurans*. I do not, however, regard this fact as of much value either for or against my argument.

5. The visible *early* changes in the skin are usually those of increased vascularity, so that the patch looks redder than the surrounding scalp; this redness is due simply to a passive dilatation of the small vessels, from impaired action of the vaso-motor nerves. The increased redness is often followed by exactly the reverse appearance—an abnormal whiteness,—due, in part, to the loss of pigment. At a still later stage we sometimes find a slight but distinct depression of the skin, which is the consequence of atrophy. The visible changes in the hair are well known, and are essentially those of mal-nutrition and atrophy of the

bulb, with absence of pigment in the new hairs. Every one of these atrophic changes is such as we should expect to result from impaired action of the trophic nerves.

6. Under the head of allied diseases, I would first refer to the fact that we occasionally meet with circumscribed patches of gray hair following neuralgia and other nervous symptoms, *unattended with baldness*, and which present all the appearances of area in process of recovery; and we also meet with what I would call, for convenience, traumatic area, of which our President, Mr. Erasmus Wilson, has recorded several cases where a local disturbance of nutrition has been produced by a blow, sting, or some other external cause.¹

Let me briefly recapitulate the three leading features of the disease. They are: (1) a strong tendency to recur; (2) local functional nerve disturbances; and (3) various atrophic changes in the skin and hair, often of long duration. How are we to explain these facts in the parasitic hypothesis?

I would remark, in conclusion, that though I do not suppose there are many present who believe in the parasitic origin of area, yet, as the view is widely entertained by the profession, and is also supported by a certain number of highly scientific men, such as Malassez, Eichhorst, and others, it seems to me that a congress like the present affords an important opportunity for the *diffusion* of sound views on this and other subjects, as well as for the discussion of strictly new and more technical questions.

¹See also paper by Dr. John Collier, *Lancet*, June 11, 1881.

LUPUS ERYTHEMATOSUS.*

BY PROFESSOR KAPOSÍ, VIENNA.

I HAVE been honored by the Committee with the task of opening the discussion on the second question of our programme, to wit: "On the nature and the treatment of lupus erythematosus."

This question should, to my thinking, be pointedly put as follows: *Is lupus erythematosus an inflammatory process or a neoplastic one?* For, the answer implies the conditions under which all that constitutes this process (as its symptoms, course, and consequences) is viewed.

In all these respects it must be stated that no agreement is to be met with amongst authors and practitioners, either in theory or in practice.

After having given, more than ten years ago, an exhaustive description of this disease, which I was pleased to see met with the general acceptance of my colleagues, I was somewhat surprised by the remarks made on the subject two years ago (August, 1879), at the annual meeting of the British Medical Association, in Cork, by some of our English, as well as by some of our French, colleagues.

Since the disease is known by the name of lupus erythematosus, the name itself has been an obstacle to its being correctly understood. Practitioners have always been disposed to confound it with lupus vulgaris, or at least to bring it very near the latter. Long ago I stated that, merely to make a concession to custom, I ranked lupus erythematosus among the neoplasms, next to lupus vulgaris,

* Transactions of the International Medical Congress, London, August, 1881.

but I have always insisted upon its inflammatory nature, and on its being thoroughly different from lupus vulgaris.

Every one who knows the history of this disease, and the different names formerly applied to it, must be aware that its name was not founded upon an agreement of its symptoms with those of lupus vulgaris, but merely upon the fact that, besides the generally congruent localization of both diseases in the face, they both, also, generally end in a cicatrization of the affected skin.

But what a difference in the road which either has to traverse till they arrive at this end!

I cannot now enter into an exposition of the symptoms of lupus vulgaris which would be necessary to make my opinions perfectly clear.

You are aware that before the publication of the plates in Hebra's "Atlas" there was only one form of the disease known—*i. e.*, the form of circular patches subdivided into many varieties: first, into three, by Cazenave; and that some of the older names correspond to it, as erythema centrifuge, dartre rongeante, qui détruit en surface, etc. In the plates mentioned, two forms are depicted, which I show here: one, representing the circular form in its localization on the nose and cheeks, compared to a butterfly-shape; and on the other plate, a disease consisting of discrete and lentil-sized patches of an otherwise well-pronounced character. But none—not even Hebra himself—made any distinction between them. Nor do I. On the contrary, I have for a special purpose taught that the process generally begins by the small spots, which I have called the "primary eruptive spots" (*primär-efflorescenzen*) of lupus erythematosus.

I need not fully describe these spots before a meeting of professional brethren; but I merely state that every spot is characterized by a red, elevated, hyperæmic, and infiltrated border, and a central cicatrix-like depression, smooth, or covered with a dry, firmly-adherent scab.

But as to the further development of the process, I have been compelled to distinguish two forms, which I have designated: first, as lupus erythematosus *discoïdes*; and second, as lupus erythematosus *aggregatus*.

The discoid form, which results from the spreading of single spots peripherally, is generally characterized by an exceedingly chronic course, not only of the individual patches, but also of the process as a whole. Further, it is usually confined to the region of the face and the head (including the mucous membrane of the mouth), occasionally attacking the fingers also.

Even in this form the clinical symptoms are easily recognized as belonging to an inflammatory process. This is strikingly expressed in the attribute "congestiva," which Hebra originally applied to the disease, and may be seen from the disappearance of the redness under the pressure of the finger, and its reappearance when the pressure has ceased; from the character of the infiltration; from the quick outbreak of hyperæmia, and its frequent disappearance without any trace; and last, not least, from the symptoms of very high and acute inflammation which occasionally complicate the discoid form, but which emphatically belong to the second form of the disease.

In the latter, to wit, in lupus erythematosus aggregatus, the symptoms of inflammation are far more striking.

Even in the lowest state of the disease, which has been called *seborrhœa congestiva*, from its character (congestion and its consequence: abundant secretion of the sebaceous glands), no doubt can arise concerning its inflammatory nature. So it is also in the other forms of eruption.

Patches of the size of a pin's head or a split lentil to that of a finger-nail, arise suddenly, slightly elevated, hyperæmic, hot and hard to touch, paling under pressure, burning; in brief, on the whole, not unlike *urticaria* spots, or those of *erythema urticatum*, or the first stage of *eczema*. As yet there is nothing characteristic of *lupus erythematosus*. There may appear single ones, twenty to one hundred and more, crowded in the face, or dispersed in other parts of the body. Many of these spots may disappear in the course of a few days without leaving any trace behind, while some of them remain and become characteristic by the atrophic depression of the centre.

It is known that what I have called *lupus erythematosus*

aggregatus consists of such forms, and that the disease does not spread in this variety by increase of individual spots, and their transformation into disks, but by the augmentation of the number of single spots, which are crowded locally into large, uniform patches, and in their dispersion over large parts of the body.

Every outbreak of this kind may be accompanied by higher degrees of inflammation and exudation of the skin, so as to form crusts and scabs, as in eczema ; or even blebs, as in herpes and pemphigus, with serous, purulent, or hemorrhagic contents.

I must not forget to call your attention to the inflammatory and painful tumors, which I have described as arising acutely in the depths of the subcutaneous cellular tissue, in the joints, and in the glands, over which, after a few days, patches of lupus erythematosus are formed, while this deep infiltration disappears ; and, above all these, to the state of inflammation of the face, which I have described and designated as *erysipelas perstans faciei*, which often leads to death.

I find it superfluous before such an audience to further detail the clinical symptoms, all pointing to an inflammatory process.

The same thing is proved by the result of anatomical investigations which have been made by Neumann, Geddings, Thin, Stroganow, Geber, and others, and by myself.

Whereas it was formerly believed that there was merely an inflammation of the sebaceous glands and the subjacent tissue, I was able to show that the anatomical changes belonging to inflammation may be found in any layer of the skin, superficially or more deeply ; and that very often they are met with in the depths of sweat-glands, spreading from there, along the blood-vessels, into the papillar layer of the skin. Also the hemorrhages, the formation of blebs and pustules above mentioned, are among the symptoms of the inflammatory congestion and changes of the blood-vessels ; whereas the numerous telangiectases, which are apt to remain at the very place of the lupus patches, are merely a consequence of the cicatrization, as may happen also in cicatrices of other origin.

To further penetrate into the nature of the process, we must inquire: *What kind of inflammation is it which so rapidly leads to the cicatrization of the skin?*

The question must be divided into two parts. First, *What is going on locally?* And in the second place, *What remote causes may underlie the process?*

As to the first, I may affirm that this is not a cicatrix, properly speaking, but a local atrophy of the skin.

I have demonstrated, in my publications of 1870, that in the midst of the inflammatory changes of the tissues, and at a very early age, fatty and molecular cloudiness of the cells of the rete and the glands, and of the formed elements resulting from inflammation, make their appearance. A similar, or a hyaloid, or a waxy degeneration takes place in the connective-tissue elements of the papillary layer, and of the blood-vessels, in consequence of which they in part become absorbed, and in part shrivel up, whilst the follicles also disappear, the blood-vessels become partly dilated, partly obliterated; briefly, all the symptoms of cicatricial degeneration and atrophy, including telangiectases, are to be recognized.

But for us it is essential to remember that many other processes of an inflammatory character and of cellular infiltration end in cicatrization; or, rather, in cicatrix-like atrophy, as scleroderma, lichen ruber, lichen scrofulosorum, and others; whereas, the true cicatrix is the organized product of granulation—that is, of a neoplasm.

The remote cause may also be considered as belonging to the *etiology* of the disease.

To me it is obvious that in many cases the affection has begun as a local disease, and runs its whole course locally, without in the least affecting the constitution during the whole duration of the malady. I remember cases in which lupus erythematosus has proceeded from a seborrhœa of the nose and face, which had its recent origin in the scars of small-pox. In these cases there is not the least inducement to consider it as a constitutional disease.

I mention another fact, which has also been pointed out by others, that two thirds of the cases of lupus erythema-

tosus are to be met with in females, and that the latter are mostly chloranæmics. But this is by no means peculiar to lupus erythematosus, which, moreover, frequently occurs in healthy females, and also in men.

But undoubtedly we must affirm the existence of a decided sympathy of the whole organism in these stages, which I have called acute general eruption of lupus erythematosus.

There is no doubt that the high fever, the symptoms of pressure on the brain, the typhoid state, the vomiting, the pleuro-pneumonia, the delirium, sopor, and the convulsions which we have observed in such cases, are in immediate relation to the inflammatory process of the skin, as also the affections of the joints, the bones, the glands, the erysipelas perstans faciei—in short, the outbreak,—and to the exacerbation of characteristic lupus spots.

Of course here we might ask: *Whether the eruption is a consequence of a disorder of the nervous centres, or the reverse?*

Although I think I have seen more autopsies in connection with this disease than any one else, yet I could not give a decided opinion.

I have observed 8 cases of death in the number of 53 cases of lupus erythematosus (18 men, 35 women) treated in the Vienna clinic in the course of ten years, 1871–1881. Amongst these eight cases, were two men and six women.

The autopsies have shown in six cases pleuro-pneumonia, in two cases tuberculosis pulmonum, as immediate causes of death. Besides that, atrophy of the brain and œdema of the meninges (once marasmus and anæmia) have been noticed. In a case of lupus erythematosus acutus, fatal last year, Jarisch has found inflammatory changes of the middle lateral parts of the anterior cornua of the medulla, as well as in its commissures. But neither this case, nor the results of investigation we have made in a case of lupus erythematosus acutus, fatal during this year, of the medulla spinalis, the intervertebral ganglions, and those of the sympathicus of the neck, could as yet authorize us to the opinion that the primary cause of the disturbance lies in

the 'hypothetic trophic centres, or in the centre of vaso-motor nerves.

On the other hand, it is not unusual for us to see that, in consequence of undoubtedly local diseases of the skin, as burns, cauterization, loss of epidermis to a great extent from any cause, the severest symptoms of fever, of nervous disorder, singultus, convulsions, sopor, vomiting, and even death may ensue.

I am not inclined to interpret these symptoms otherwise, than that they may be provoked by reflex action from the affected skin. We are taught to do so by many other observations made in dermato-pathology; and we find this opinion here more convenient than that of neuritis ascendens.

Still there remains a wide field for the theory of general repression of nutrition, which may cause the degenerative character of the inflammation. But neither is such a state of general weakness to be found in all cases, nor can it explain the outbreak of the inflammation itself.

Before closing, in regard to the pathology of the disease, I submit another question: *Whether my division of lupus erythematosus does not most correspond to the clinical features?* For, to me, it seems that the subdivisions according to certain morphological differences—as erythematosus, or hemorrhagic, or acneic—do not touch any of the essentials, while division of discoid and aggregate, though making no difference as to origin, still indicates the twofold manner of the clinical process: one chronic and indifferent, and the other acute, severe, and even fatal.

Now I pass to the practical question of the best *treatment*. On this I shall be short.

The general and etiological conditions have given us no indications for an efficacious treatment. For, whatever generally invigorating remedy is given, as iron, cod-liver oil, strengthening diet, etc., it has no direct influence on the disease. About iodine with starch, recommended by McCall Anderson, and the iodoform, approved in two cases by our distinguished friend, E. Besnier, I have no sufficient experience. That the anti-syphilitic therapeutics are of no use at all I have amply experienced.

On the other hand, we are, as you are aware, very rich in external and local remedies. To the all but exhaustive number I published in 1869, I may at present add a few new ones, as sublimate-collodium, salicylic acid, pyrogallic acid, chrysarobin, iodoform, and naphthol, introduced by me.

Further, I can but repeat my former words, that each remedy and method of procedure may be found thoroughly efficacious in lupus erythematosus, but that this statement only applies to particular cases, since a method which has been put to the test in a number of cases successfully, will leave us in the lurch in the very next case.

In judging of the efficiency of any remedy, we must not forget that patches of lupus erythematosus very often disappear spontaneously, or under the slightest influences.

Of the large number of well-known remedies, all of which may be useful in special cases, the application of cold not excepted, I have in my experience found as most efficacious: soaps in all forms, especially spiritus saponis kalinus, dilute acids and alkalies, tar, sulphur, and iodine; most particularly emplastrum hydrargyri, which I have first applied successfully; sometimes pyrogallic acid; also, naphthol; finally, mechanical treatment by puncturing, scraping with a scoop, and scarification, which are most useful in destroying the disfiguring telangiectases that very often remain in the spots of lupus erythematosus which have recovered.

LUPUS ERYTHEMATOSUS.*

BY DR. TH. VEIEL, CANSTATT, GERMANY.

[Translated by W. T. ALEXANDER, M.D.]

Respected assemblage: In response to the kind invitation of our esteemed English colleagues, I have the honor of briefly laying before you my views on the nature and treatment of lupus erythematosus.

By lupus erythematosus I mean, of course, the lupus erythematosus of Cazenave, or "of the Germans," as it is called by a portion of our English colleagues, in contradistinction to the lupus erythematosus of the English, which constitutes the mildest form of lupus vulgaris.

Fifty-five cases of this affection have been treated in the sanitarium for diseases of the skin in Canstatt, which was founded by my father, and is conducted by my brother, Dr. Ernst Veiel, and myself.

In all of these cases the course of the disease was chronic; the form of the lesions the orbicular, more rarely the disseminated; and their seat, as a rule, the nose, cheeks, eyebrows, ears, and the hairy scalp.

In the majority of the cases the disease first showed itself between the ages of twenty and forty. In only two cases did it appear before the tenth year of life, and in one after the sixtieth.

That malignant form of lupus erythematosus aggregatus described by Kaposi, Stern, and Bock, which appears with acute and subacute febrile eruptions, and spreads over the entire body, has never come under my observation in Can-

* Transactions of the International Medical Congress, London, Aug., 1882.

statt. I have seen it, however, in the year 1872, in Vienna, at the clinic of my unfortunately too-early deceased and highly-esteemed teacher, Hebra.

I propose to-day to answer the following questions concerning the nature of lupus erythematosus.

1. Is lupus erythematosus a disease *sui generis*, or is it only a subdivision of lupus vulgaris?

2. Is lupus erythematosus a partial manifestation of some well-known general disease of the organism, such as scrofulosis, tuberculosis, gout, or syphilis?

3. Does the affection of the sebaceous glands, or of the sweat-glands in situations where there are no sebaceous glands, constitute the essential element of the disease?

The answer to the *first* question is as follows:

Lupus erythematosus is an independent disease, according to its first appearance, the aspect which it presents, and its course.

This view is supported by the following facts.

The different forms of lupus vulgaris frequently run into each other, while lupus erythematosus never develops into lupus vulgaris. The simultaneous occurrence of the two diseases in one individual has never been observed, to my knowledge.

Lupus erythematosus appears in the form of small *superficial* red points, upon which firmly adherent scales are formed, which send down root-like processes between the elongated papillæ. Lupus vulgaris begins with small brownish nodules lying deep down in the cutis.

Lupus erythematosus never results in softening, suppuration, or ulceration. It never forms nodules, like lupus vulgaris.

Lupus erythematosus always remains limited to the cutis and subcutaneous cellular tissue. It never attacks deeper tissues, such as cartilage.

Lupus erythematosus is almost invariably a disease of mature life; lupus vulgaris does not appear before the period of puberty.

The *second* question must be answered as follows.

Although it cannot be denied that lupus erythematosus

frequently occurs in connection with scrofulosis, tuberculosis, gout, and chlorosis, and that its victims very often present an anæmic appearance, this is by no means the rule. One very often encounters it in perfectly healthy persons.

Although we may therefore suppose that it bears a certain relationship to the above-mentioned disease, especially scrofulosis and tuberculosis, in view of the fatal cases described by Kaposi the connection has not yet been proven to exist.

With syphilis lupus erythematosus has absolutely nothing in common, and no anti-syphilitic treatment is of any value whatever in its management.

As regards the *third* question, whether the affection of the sebaceous or sweat-glands is the essential feature of lupus erythematosus, I showed in the year 1872¹ that although in many cases the participation of the sebaceous glands in the morbid process gives a very peculiar character to the aspect presented by lupus erythematosus, the affection of these glands is nevertheless an entirely accidental feature, an opinion which has since been confirmed by the microscopical investigations of Geber, Thin, and Vidal.

The primary and essential element of the disease is the accumulation of blood corpuscles in the dilated capillaries of the papillary body and corium, and the cellular infiltration in the neighborhood of the vessels. These changes may be recognized at a time when the sebaceous and sweat-glands are still absolutely intact. The affection of the glands is the consequence of the morbid change in the vascular network which so richly surrounds them.

In this manner the fact is also explained that in some cases the acute dermatitis of variola, in others that of erysipelas, gives the first impetus to the development of lupus erythematosus. The aspect presented by lupus erythematosus varies according to the secondary implication of the sebaceous glands in the morbid process. If these are severely affected, the skin imparts a greasy sensation to the touch, and the diseased patches are covered with scales and

¹ Th. Veiel: "Ueber Lupus Erythematosus," Tübingen.

crusts rich in sebaceous matter. If the glands are but slightly or not at all affected, there is formed, from the outset of the disease, a brittle, hard, horny, thickened layer of epidermis, containing almost no fatty matter.

The view that the affection of the vessels and of the tissues around them is the primary step in the disease, is also supported by the circumstance that the points of predilection of lupus erythematosus are the places where stasis and dilatation of vessels take place in other diseases also, such as the nose and cheeks in acne rosacea, the ears, nose, and backs of the fingers and toes in frost-bites.

The observation of Oscar Simon,¹ which has been advanced in opposition to this view, that lupus erythematosus did not attack a cicatrix left by a burn, in which the follicles had been destroyed, although it developed in its immediate neighborhood, is certainly not sufficient to completely invalidate the opinion, on account of the fact that in cicatricial tissue not only the follicles but also the papillary layer of the corium and the vascular network surrounding the follicles are destroyed. We very frequently see relapses occur in young, highly-vascularized cicatrices, even when they were produced by deeply-acting escharotics, such as caustic potash, in which case we are certainly warranted in believing that the follicles were also destroyed.

Holding these opinions I believe that we should discard all designations of lupus erythematosus which are based upon the affection of the sebaceous glands, such as lupus acnéique (Hardy), lupus acneiformis (Tilbury Fox), lupus seborrhagicus (Volkman), as Hebra long ago did with seborrhœa congestiva.

Passing on to the consideration of the treatment of lupus erythematosus, I must first remark that there are some, fortunately very rare, cases of the disease, which defy all treatment, even the most energetic, in which relapses always take place in the cicatrices left after treatment.

I propose to answer the following two questions.

1. Is general treatment of lupus erythematosus indicated, in addition to local, and in what should it consist?

¹ "Localisation der Hautkrankheiten," p. 100.

2. What remedy has proved most valuable in the local treatment?

In answer to the first, I must state that we have never yet succeeded in curing lupus erythematosus by the internal administration of (other) remedies. There is no specific for this disease, iodide of potassium and arsenic have always failed in our hands. Of the iodized starch recommended by McCall Anderson we have not yet had sufficient experience. I would, however, be unwilling to abandon the attempt to strengthen the organism of the patient as much as possible, particularly since the publication of severe and fatally-ending cases of the disease. If symptoms of scrofulosis, tuberculosis, gout, or chlorosis be present, remedies should be directed to meet these indications. If such be not discovered, and there be no reason to fear them on grounds of heredity, we must content ourselves with the administration of the most nourishing food, and providing good air.

In answer to the second question, I would say that the choice of the local remedy should be determined by the individual case. Of the many agents which have been recommended we have found the following of most service.

In small circumscribed patches of lupus erythematosus sebaceus the iodide of mercury, which was recommended by Cazenave (in the strength of 1 : 5—15 of lard), has proved of exceptional value. After freeing the skin from oily matters, it should be applied until bullæ filled with pus have formed. The crusts should be allowed to dry up and fall off. In some cases the repeated application of this agent, which, unfortunately, causes great pain, becomes necessary.

Trichloracetic acid acts with greater intensity, and is much to be recommended, particularly in lupus erythematosus corneus. It is characterized by the rapidity of its action, which does not extend too deeply, by causing but moderate pain, by the exact limitation of its effects to the point of application, by the fact that it produces only a slight degree of inflammation in the neighborhood of the eschar, and that it leaves smooth scars behind. It is much to be preferred to the majority of other acids. It is best applied with a

glass brush, and then bored into the eschar with a glass rod.

For use on larger surfaces we prefer the pyrogallic acid, which was recommended by Jarisch, to the above-mentioned agents. It is applied for three or four days, in the form of an ointment (1 : 10 of vaseline), and the result after removal of the slough is sometimes very surprising.

If none of these remedies produces the desired result, we do not resort to the method of scraping with the sharp spoon—after which relapses always occur,—but employ multiple scarification (which acts much more deeply), with subsequent cauterizations with chloride of zinc. Without the latter, the results are bad. We are in the habit of performing the operation with the instrument invented by my brother in 1873,¹ and since improved, which consists of six lancets placed side by side. After the hemorrhage is arrested a concentrated alcoholic solution of chloride of zinc is painted on the part. On account of the great pain attending the operation, local anæsthesia should be produced by means of Richardson's ether atomizer in the case of small patches ; if larger surfaces are to be scarified, chloroform should be administered.

If, finally, the foregoing remarks are collected together, the following propositions may be formulated.

1. Lupus erythematosus is an independent disease and not a form of lupus vulgaris.

2. A connection between lupus erythematosus and scrofulosis, tuberculosis, and syphilis cannot be established.

3. The affection of the sebaceous or sweat-glands is an accidental accessory phenomenon. The essential nature of lupus erythematosus consists in the pathological alterations which are found along the course of the blood-vessels.

4. No remedy has as yet been discovered, the internal use of which produces a cure of lupus erythematosus.

5. The most efficient local remedy for lupus erythematosus is multiple scarification, in connection with subsequent cauterization with chloride of zinc.

¹ *Archiv für Dermatologie und Syphilis.*

Clinical Reports.

CLINICAL ILLUSTRATIONS OF DISEASES OF THE SKIN.*

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IX. **Acne.**—The diseases of the sebaceous glands, which are grouped under the general name acne, form a considerable proportion of the cases of cutaneous disease applying for treatment. They are divided into two general classes : first, those manifesting only conditions of faulty secretion and excretion ; and, second, those exhibiting inflammation of the sebaceous glands and of the surrounding tissues. The first embraces the varieties of seborrhœa and comedo ; the second, the varieties of acne proper, namely, acne simplex, indurata, and rosacea.

ACNE SEBACEA.—Synonyms : *Seborrhœa* ; *Seborrhagia* ; *Steatorrhœa*. Three distinct conditions, if not four, are clearly to be made out, exhibiting various modes of functional derangement of the sebaceous glands : *a*, when the secretion is too abundant and

* The very favorable reception which was accorded to the "Notes on the Local Treatment of Certain Diseases of the Skin," until most of the diseases which are at all common were gone over, in previous issues of these ARCHIVES, leads the editor to continue this plan of serial writing for general practitioners in the form of "Clinical Illustrations of Diseases of the Skin." It is intended in these to give plain and practical comments on dermatological subjects, based on illustrative cases taken from private and public practice, some of the matter at times being that delivered in clinical lectures at the New York Hospital. The disease will, as far as practicable, be treated of in the order in which they occur in the classification commonly found at the beginning of the Digest Department. These notes are continued from pages 60, 139, 261, and 399 volume vi ; from pages 162, 301, and 403, volume vii ; and from page 29, volume viii.

too oily, *seborrhœa oleosa* ; *b*, when the secretion is very abundant and concretes into scales, *seborrhœa cerea*, or *sicca* ; and, *c*, when it hardens into almost horny masses, *seborrhœa cornea*. A fourth state may be added, when the secretion is abnormally diminished, or absent, giving the skin a hard, slightly roughened aspect.

Seborrhœa oleosa.—In most cases this only presents an unnaturally greasy surface, the oily, shiny appearance returning very shortly after it is cleansed. In the following case the secretion was so great as at times to stand in minute drops on the affected part.

Mrs. J., aged 35, had chloasma on the centre of the forehead, for which she had applied a strong lotion of bichloride of mercury by the advice of a physician. The discoloration returned, and she again used the remedy, with the result of causing considerable irritation of the skin. For the year previous to her consulting me the surface between the eyes had been red and shiny, with a constant secretion of oily matter. Her general health was poor ; she was nervous, constipated, and dyspeptic. The condition of oily seborrhœa proved most rebellious, resisting various local and internal medication. On several occasions it was noted that the secretion was so excessive that minute drops of oily matter could be seen at the orifices of the sebaceous glands.

Seborrhœa cerea or *sicca* is more common on the scalp than on the face, but occasionally it proves very annoying in the latter situation, forming a thick, greasy coating of scales which re-form as often as removed, and unless properly treated may recur for an indefinite period. The most common situation for this is on the nose, and cheeks immediately adjoining. In the following case the entire forehead was the seat of this perverted gland action.

Miss K., aged 32, consulted me January 30, 1882, for the condition of the forehead, which was the seat of a moderately active seborrhœa. The surface was a little reddened, greasy, and with abundant, slightly-adherent scales ; the sides of the nose presented also a well-marked sebaceous scaling. Her general condition was poor, tongue white and indented, digestion apt to be bad, and with occasional palpitation of the heart. She was given an alkaline and bark tonic, and the following lotion : \mathcal{R} Potass. sulphureti, zinci sulphatis, \overline{aa} , \mathfrak{z} i ; aquæ rosæ, \mathfrak{z} iv ; \mathfrak{m} ; ft. lotio. Ten days later it was recorded that there was very great improvement, and one month subsequently the forehead appeared normal, except for a very moderate amount of redness.

Upon the chest, and sometimes on the back, seborrhœa presents appearances which are not always recognized, but which are quite

uniform and characteristic ; the eruption consists of more or less circular patches, slightly reddened and elevated, quite sharply defined, and covered with greasy scales. These patches may itch considerably, and are liable to be mistaken for eczema, psoriasis, and tinea versicolor ; but under the microscope the scales are found to consist very largely of fatty matter, and no parasite can be found.

Seborrhœa of the scalp exhibits one or two different phases which may be best illustrated by cases : the dry, branny form of desquamation is most common, and represents a large number of the cases commonly called "dandruff."

Mr. P., aged 42, had for many years been subject to a very scaly condition of the scalp, and consulted me March 14, 1882, on account of the falling of the hair, which had been more pronounced during the preceding few months than formerly. He was a hard-working gentleman, with large moneyed interests, but retained his health and vitality very well. The entire scalp was found to be the seat of a scaly incrustation of sebaceous matter, and on the top the masses were much thicker, more yellow, and more firmly adherent than elsewhere ; here, however, they could be easily scraped up, and formed a greasy, waxy mass. The hair was still very abundant. He was given the following remedies : \mathcal{R} Plumbi acetatis, gr. viii ; olei ricini, \mathfrak{z} iv ; alcohol, \mathfrak{z} iiiss ; \mathfrak{M} ; to be freely applied and gently rubbed in night and morning ; internally he took a tonic of bark, nux vomica, and acetate of potassa. A week later it was noted that the scaling was much less, and the scalp felt more natural. He was then directed to wash the head thoroughly with tar soap once a week or two, and to apply well to the roots of the hair the following ointment : \mathcal{R} Acidi tannici, \mathfrak{z} i ; unguenti aquæ rosæ, \mathfrak{z} i ; \mathfrak{M} ; ft. unguent. Under this treatment the hair ceased to fall and the scaling disappeared.

In many cases the functional disorder on the scalp will be associated with one of the forms of inflammatory acne of the face, as in the following instance :

Miss H., aged 17, a strumous-looking girl was brought to my office February 25, 1881, for the treatment of the scalp ; she was very bright and precocious, but was apt to become run down from overwork. For many years her scalp had been the seat of very considerable dandruff, and of late the encrusting had been so considerable that relief was sought.

The whole scalp was found to be the seat of a greasy scaling, which extended even down upon the forehead ; beneath the scales, which were easily detached and in some places came off in adherent masses, the skin was normal ; the whole face presented

a moderate number of comedones and papules of acne simplex. She was given a mixture of magnesia, iron, and sulphuric acid, to take after meals, and locally an ointment of tannic acid, a drachm to the ounce, to be thoroughly applied every night; on the sixth night the scalp was to be thoroughly washed with tar soap, and the ointment immediately reapplied. When next seen, March 5th, the scalp appeared normal, and under continued treatment for a while remained well, tonic and stimulation lotions with cantharides, capsicum, and castor oil being used later. The acne of the face proved much more rebellious of permanent cure, and a year later still gave some trouble.

ACNE PUNCTATA, or comedones, are common enough, in connection with other forms of acne, and these "black-heads" or "flesh worms" are often very annoying on the faces of young people. In some instances they are the sole manifestations of sebaceous disorder, and occasionally are so very abundant and seriously disfiguring as to call for active treatment. The following case presented an aspect such as I had never seen before, as regards the immense number and great size of the obstructing sebaceous plugs:

Miss K., aged 22, was sent to me by Dr. T. G. Thomas, November 4, 1876, for the possible relief of the condition of the face, which was the cause of very great anxiety in view of her approaching marriage, in a few weeks. She was considered to be in fair general health, but inquiry revealed the fact that she was habitually constipated, that she was subject to sick headaches, and that the menses were painful and profuse; this latter state had greatly improved under the treatment of Dr. Thomas. Menstruation began at the age of fourteen, and the face was noticeably affected with acne simplex at sixteen years of age; within the year or two previous to her visit the character of the skin lesion had changed, the inflamed points ceasing as the numerous comedones appeared, increasing in numbers since. She had had no treatment for the face, but a certain "Mrs. Shaw's lotion," which had increased the trouble greatly.

On examination the whole face, forehead, nose, and chin were literally covered with hundreds of black specks, of various sizes, giving to the face at a little distance a very dingy appearance, but near by the separate points were readily distinguishable. Very many of the plugs were removed by the comedo extractor, and she was directed to soak the face with very hot water every night on retiring; then to remove as many as possible herself, and to apply thoroughly the lotion of sulphuret of potash and zinc before referred to. She was also directed to take Kissingen water in small doses three or four times daily, in quantity sufficient to act slightly upon the bowels. At subsequent visits numbers of

comedones were removed, as many as a hundred at a sitting, as also some at home, and she was given pills of aloes and iron ; within four weeks it was noted that the complexion presented a very clear appearance, entirely free from the black specks for the relief of which she had come.

Remarks.—While some stress has been laid upon the local treatment of functional sebaceous disorders, it is to be remembered that proper internal, dietary, and hygienic measures are of the very greatest importance for the complete and permanent removal of the difficulty. These signs of imperfect action of the lining cells of the sebaceous glands but indicate lowered vitality, which these tissues share in common with the rest of the economy. I have very many instances on record to prove that as the general health gained, as, for instance, during a vacation and outdoor life, with exercise, the sebaceous disorder vanished ; and, on the other hand, many instances in very intelligent patients, several of them physicians, where each attack of digestive disorder was surely followed by derangement of the sebaceous glands, exhibited by seborrhœa.

The accumulations within the cavities and ducts of the glands take place readily on the face, because of the absence of the assistance to excretion afforded by the *arrectores pilorum* pressing upon glands attached to large hairs elsewhere ; but this accumulation does not occur until the glands secrete cells which are imperfectly transformed into oily matter, and the skin and tissues are in a generally lax and feeble condition. The importance of proper tonics, therefore, in all the forms of sebaceous disease cannot be overestimated, although often it will be very difficult to have the tonic act rightly, owing to errors in assimilation, which must be corrected at the same time or previously ; this matter, as also that of diet will be more fully dwelt upon in connection with the inflammatory forms of acne.

The local treatment has been somewhat indicated in the cases quoted ; while avoiding too great stimulation, some astringent action must be effected. For the scalp nothing acts better than tannin in ointment, but care must be exercised in not washing too much, and in reapplying the ointment immediately after rinsing the scalp. Citrin ointment, thrice diluted, is an excellent remedy in more rebellious cases. Later, stimulating lotions may be employed, but sometimes they do harm, and the milder measures must be long persisted in to effect a cure.

Digest of Literature.

CLASSIFICATION OF DISEASES OF THE SKIN.

- CLASS I. **Morbi cutis parasitici.** Parasitic Affections.
 " II. **Morbi glandularum cutis.** Glandular Affections.
 " III. **Neuroses.** Neurotic Affections.
 " IV. **Exsudationes.** Exudative or Inflammatory Affections.
 " V. **Hæmorrhagiæ.** Hæmorrhagic Affections.
 " VI. **Hypertrophie.** Hypertrophic Affections.
 " VII. **Atrophie.** Atrophic Affections.
 " VIII. **Neoplasmata.** New Formations.

Class I. **Morbi cutis parasitici.** Parasitic Affections.

- A. VEGETABLE.
1. *Tinea trichophytina* { corporis (or *tinea circinata*).
 (or *trichophytosis*) { capitis (or *tinea tonsurans*).
 (*parasite—Trichophyton tonsurans*). { barbæ (or *sycosis parasitica*).
 { cruris (or *eczema marginatum*).
 2. *Tinea favosa* (*parasite—Achorion Schænleinii*).
 (or *favus*)
 3. *Tinea versicolor*
 (or *chromophytosis*) (*parasite—Microsporon furfur*).
- ANIMAL.
1. *Phthiriasis* { corporis
 (or *pediculosis*) { capitis
 { pubis } (*parasite—Pediculus*).
 2. *Scabies* (*parasite—Acarus scabiei*).

Class II. **Morbi glandularum cutis.** Glandular Affections.

- DISEASES OF THE SEBACEOUS GLANDS.
- I. Due to faulty secretion or excretion of sebaceous matter.
 1. *Acne sebacea* { oleosa } (or *seborrhœa*).
 { cerea }
 { cornea }
 2. *Acne punctata* { nigra (or *comedo*).
 { albida (or *milium*).
 3. *Acne molluscum* (or *molluscum sebaceum*).
 - II. Due to inflammation of sebaceous glands with surrounding tissue.
 4. *Acne simplex* (or *vulgaris*).
 5. *Acne indurata*.
 6. *Acne rosacea*.
- E DISEASES OF THE SWEAT-GLANDS.
- I. As to quantity of secretion.
 1. *Hyperidrosis*.
 2. *Anidrosis*.
 - II. As to quality of secretion.
 3. *Bromidrosis*.
 4. *Chromidrosis*.
 - III. With retention of secretion.
 5. *Dysidrosis*.
 6. *Sudamina*.

Class V. Hæmorrhagiæ. Hæmorrhagic Affections.

- | | | |
|------------------------------------|---|--------------------------------------|
| 1. Purpura | { | simplex. |
| | | papulosa. |
| | | rheumatica (or peliosis rheumatica). |
| | | hæmorrhagica. |
| 2. Hæmatidrosis (or bloody sweat). | | |
| 3. Scorbutus. | | |

Class VI. Hypertrophix. Hypertrophic Affections.

- | | | | |
|------------------------------|---|---|----------------------------|
| A. OF PIGMENT. | { | 1. Lentigo. | 4. Nævus pigmentosus. |
| | | 2. Chloasma. | 5. Morbus Addisonii. |
| | | 3. Melanoderma. | |
| B. OF EPIDERMIS AND PAPILLÆ. | { | 1. Keratosis pilaris (or lichen pilaris). | |
| | | 2. Ichthyosis. | |
| | | 3. Cornu cutaneum. | 6. Verruca { |
| | | 4. Clavus. | vulgaris. |
| | | 5. Tylosis (or callositas). | senilis. |
| C. OF CONNECTIVE TISSUE. | { | 1. Scleroderma. | 4. Elephantiasis (Arabum). |
| | | 2. Sclerema neonatorum. | 5. Dermatolysis. |
| | | 3. Morphœa. | 6. Frambœsia (or yaws). |
| D. OF HAIR. | | 1. Hirsuties. | 2. Nævus pilosus. |
| E. OF NAIL. | | 1. Onychogryphosis. | 2. Onychauxis. |

Class VII. Atrophix. Atrophic Affections.

- | | | | |
|----------------|---|--|------------------------------|
| A. OF PIGMENT. | { | 1. Albinismus. | 2. Leucoderma (or vitiligo). |
| | | 3. Canities. | |
| B. OF CORIUM. | { | 1. Atrophia cutis { | propria. |
| | | linearis (or striæ atrophicæ). | |
| | | maculosa (or maculæ atrophicæ). | |
| | | 2. Atrophia senilis. | |
| C. OF HAIR. | { | 1. Alopecia. | 2. Alopecia areata. |
| | | 3. Trichorexis nodosa (atrophia pilorum propria, or fragilitas crinium). | |
| D. OF NAIL. | | Onychatrophia. | |

Class VIII. Neoplasmata. New Formations.

I. BENIGN NEW FORMATIONS.

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|---------------------------|---|--|-------------------------------------|
| A. OF CONNECTIVE TISSUE. | { | 1. Keloid. | 2. Fibroma (or molluscum fibrosum). |
| | | 3. Xanthoma (xanthelasma or vitiligoidea). | |
| B. OF GRANULATION TISSUE. | { | 1. Lupus { | vulgaris. |
| | | erythematosus. | 2. Scrofuloderma. |
| | | | 3. Rhinoscleroma. |
| C. OF BLOOD-VESSELS. | { | 1. Nævus vasculosus. | |
| | | 2. Angioma (or telangiectasis). | |
| D. OF LYMPHATICS. | { | 1. Lymphadenoma cutis. | |
| | | 2. Lymphangioma cutis. | |
| E. OF NERVES. | | Neuroma cutis. | |

II. MALIGNANT NEW FORMATIONS.

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|-----------------|---|---------------|---|---------------------------------------|
| 1. Lepra | { | tuberosa | { | (leprosy, or elephantiasis Græcorum). |
| | | maculosa | | |
| 2. Carcinoma. | | | | |
| 3. Epithelioma. | | | | |
| 4. Sarcoma | { | idiopathicum. | { | (or melanosis). |
| | | pigmentosum | | |

DISEASES OF THE SKIN.

ANATOMY, PHYSIOLOGY, AND PATHOLOGY.

MALCOLM MORRIS, F.R.C.S. EDIN., OF LONDON, ENG.

On the development of hairs.—RENAUT, in studying the development of hairs, finds that the layer of Henle is the continuation of the stratum lucidum of the epidermis, the nuclei of which have undergone atrophy, as in the horny layer of the epidermis, just as the outer root-sheath is derived from the rete. In the fœtus of 7 months, the layer of Huxley contains numerous translucent granules which have the refractive power and reactions of keratin, and begins exactly where the process of cornification of the hair-forming cells is taking place.—*Comptes rendus de l'Académie des Sciences*, 1880, p. 1086.

Researches on animal heat.—D'ARSONVAL finds that the quantity of heat evolved by the body does not correspond either to the amount of oxygen absorbed or carbonic anhydride excreted in a given time. Many reactions in the body are accompanied by an evolution of heat without formation of carbonic acid, and, in some cases, as Moilessier has also shown, the absorption of oxygen and evolution of carbonic acid is accompanied (*e. g.*, in the incubating egg) by an absorption instead of a liberation of heat.—*Comptes rendus*, etc., 1881, p. 83.

On the terminations of sensory peripheral nerves.—KRAUSE, in a long and carefully worked-out article, describes the various terminations of sensory peripheral nerves, to which he applies the collective name of "terminal corpuscles." They all have the common feature of the ending of the nerve filament in a bulbous or flattened knob, surrounded by the so-called "inner-bulb," derived from the cells originally nucleated, which have formed the sheath of Schwann. The outer coats are derived from the altered perineurium of the fibre. He enumerates thirteen varieties of terminal corpuscles in the different classes of vertebrata, which form a series of gradually increasing complexity.—*Archiv. f. mikroskop. Anat.*, Berlin, 1880–1, xix, p. 53.

Experimental researches on the absorption of mercury.—FURBRINGER found that after the inunction of blue ointment (ung. hydrarg.) into the skin of rabbits, metallic mercury could be found in the hair follicles and sebaceous glands, but never in the rete Malpighii. If the epidermis were previously removed, or the capillaries of the cutis injured, the globules could be found in the layers of the cutis, in the vessels, and, in a few

cases, in the subcutaneous tissue. After a limb had been exposed for a long time to the vapor of mercury in a closed vessel, and a gray precipitate had formed on the surface, no trace of the metal could be found in the cutis, or in the hair follicles and sebaceous glands.

He also injected a mercury-and-gum emulsion into the blood, and found that part of the metal became dissolved. The globules disappeared from the skin probably by solution in the fatty acids of the sebum; a week after the last inunction they were very scanty, and, in accordance with Neumann's observations, they had disappeared in a month's time.—*Archiv. f. path. Anat.*, Berlin, 1880, lxxxii, p. 491.

New researches concerning the organs of touch.—RANVIER, having previously shown that the nerves themselves terminate, in the corpuscles of touch of the beak and tongue of web-footed animals, by means of disks situated between special cells (tactile disks and cells of touch), has extended his researches to other organs, and ascertained that among different domestic animals the tactile disks are analogous to those already described. As for the corpuscles of touch in man, it is by the study of their development that their structure can be ascertained. In the new-born child we see the nerves of touch mounting up into certain papillæ of the palmar surface of the fingers and terminating at their summits, directly underneath the first row of the mucous corpuscles of Malpighii, forming an arborization whose branches are heaped up on one another; at this time, this terminal arborization, which represents the embryonal corpuscles of touch, does not have any kind of cellular elements mingled with it, but there exists beneath it a small mass of round, transparent, and very clear cells. But on pursuing this examination on infants of different ages, it is found that little by little these small cells, at first heaped up beneath the terminal arborization, spread out on the sides, enveloping and insinuating themselves between these branches. Very soon this limits itself, and so a lobe of the corpuscle of touch is formed. Nerve fibres are never seen accompanying corpuscle cells, but the branches of arborization freely terminate by means of knots more or less flattened.—*Comp. rend. Acad. des Sciences*, Paris, Dec. 27, 1880; *Rev. des Sciences Méd.*, Jan. 15, 1882, p. 16.

Contribution to the anatomy of some of the lymphatic glands in adult and fœtal life.—In an article on the above subject, CHIEVITZ says that the lymphatics of the inguinal region in man are very poorly provided with connective tissue, scarcely any being found in the periphery and in the cortical zone of the ganglion; the medullary portion is almost totally deprived of it.

In the human embryo the rudiments of lymphatic ganglia appear, about the eleventh week, in the midst of cellular tissue; they are known by the multiplication of the nuclei and by the appearance of free lymphatic cells, which, in time, transform themselves

into adenoid tissue. In the midst of these cells fissures are found, the number of which is continually increasing, and which together form the system of lymphatic sinuses. The lymphatic channels are free in the beginning; the trabeculæ and walls are developed secondarily.—*Archiv. f. Anat. u. Phys.; Anat. Abth.*, Heft. 4 u. 5, 1881; *Rev. des Sciences Méd.*, Paris, April 15, 1882, p. 410.

The anatomy of the sudoriparous glands.—FICATIER, in a study of the comparative anatomy of the sudoriparous glands of different parts of the skin in man and many animals, says that they may be divided into three kinds: the sudoriparous glands proper, the special glands, such as the ceruminous and those of Moll; and the odorous glands, such as those found in the axilla, folds of the anus, and around the areola of the breast. All these glands, of whatever size or in whatever animal we find them, present the same histological features. The differences which exist between the three species pertain more particularly to their secreting epithelium. In the sudoriparous glands proper, the secreting cells are pyramidal, very much elongated, and without cuticle; in the axillary glands these cells are either cubic with a fine hyaline cuticle, or prismatic. The latter have on their summit a hyaline portion, which forms a projection more or less marked. Two kinds of secreting cells are also found in the glands of the external auditory canal: the one form being of the pavement variety, elongated with a cuticle, presenting a very fine horny appearance; the other, prismatic and resembling the cells of the axillary glands. The author regards the muscular tunic in the walls of the sudoriparous glands, as a basilar epithelial layer.—*Thèse de Paris*, 1881; *Rev. des Sciences Médicales*, Jan. 15, 1882, p. 11.

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NEUROSES AND HEMORRHAGES.

GORHAM BACON, M.D.

Purpura hemorrhagica, as it affects the uterus during menstruation and pregnancy.—PUECH has reported several cases of purpura hemorrhagica, as observed by himself, and the conclusions he arrives at are that, if the disease be mild, it may have but little effect on the uterus, but if of a severe nature, menstruation may be very difficult and menorrhagia or metrorrhagia may occur. Should the disease become chronic, the catamenia may be suppressed and hemorrhagic spots beneath the skin be found on different parts of the body.

During the pregnant state the disease has a tendency to produce abortion or premature labor.

The prognosis is always grave, but the disease is more fatal among women than among men, and it is much more to be dreaded during pregnancy. When metrorrhagia occurs the prognosis then becomes very unfavorable.—*Annales de Gynecologie*, Oct., 1881.

Case of scorbutic spinal hemorrhage.—The patient, a young lady, æt. 13, who had been ill for four months with pulmonary disease, was suddenly seized five days previously with severe pain and constant spasmodic startings and jerkings of both legs and thighs. When first seen, she was confined to bed in a most constrained position, and it required considerable strength for the nurse to hold the limb down to prevent the constant painful jerkings which immediately occurred whenever the restraint was removed. This condition had existed for the previous forty-eight hours, night and day, and although she had been somewhat quieted by opium, she had obtained but little rest. She was naturally of a pale and delicate constitution, having lost several relatives from consumption, and had suffered from otorrhœa since the age of one year. An examination of the lungs showed dulness, feeble breathing, and large, moist râles; pulse small and weak; temperature 100° F.; urine free from albumen. There was an entire freedom from pain along the spine and limbs when the spasmodic startings were restrained; the sensation in the legs was unaffected; no spasmodic jerkings were produced by merely touching the skin, although the spasms immediately recommenced when the pressure of the nurse's hands was removed from the thighs. On further inquiry, it was ascertained that for the preceding three weeks there had been recurring small hemorrhages under the skin of the legs, and it was also elicited that she had great dislike for fruit and vegetables—rarely eating any. Considering these additional facts, it was decided that she was suffering from a scorbutic hemorrhage into the membranes of the lower part of the spinal cord; that the spasmodic startings were due to this condition. She was immediately given small and frequently repeated doses of lemon-juice, and directed to

take tincture of belladonna or opium if restlessness continued. After four days the symptoms began to disappear ; she commenced to regain power over her limbs, and at the end of six weeks she was up and walking about, with the aid of sticks, and was greatly improved in health.

EADE in his practice has met with several cases of scurvy among well-nourished and well-to-do patients, and the diseased condition appeared to have been induced either by eccentricity of diet, by over-care as to non-use of foods which were thought not to agree, or by prolonged use of liquids only, such as milk, gruel, or beef tea, which had been prescribed for some dyspeptic disorder.—*British Med. Journal*, Nov. 19, 1881.

Two cases of scurvy, with some remarks upon the etiology of that disease.—Two cases are recorded by COSKERY, and in neither of them could the disease be traced to a want of a vegetable diet. Both were well-marked cases, and the food consisted of that generally used by the laboring classes. The cases were brought forward to show that diet is not the only cause of the disease, and that cases are continually recorded in civil practice, and are not confined simply to soldiers and sailors. Although the absence or deficiency of vegetable diet in the production of attacks of scurvy is too well established to admit of doubt, are we right in ignoring all other causes? It seems that any condition in which the plasticity of the blood and the normal resiliency of the vessels is decreased, such as may occur in many wasting diseases, may lead to extravasations, superficial and deep, and to accumulations of blood. Niemeyer says "that the hypothesis regarding the preponderance of the soda salts over those of potash in scorbutic blood is overthrown by the fact that it also appears among people whose diet is almost entirely vegetable, but who suffer from destitution and live in cold, moist cellars, as is the case especially in Russia."—*Maryland Med. Journal*, Aug. 1, 1881.

Zona secondary to genito-urinary diseases.—A patient æt. 19, contracted gonorrhœa in Sept., 1880, for which he applied to a specialist, who treated him with numerous injections, which at the time diminished the discharge, but only to appear again as profuse as ever.

He came under observation in February, at which time he complained of severe pains after micturition, which lasted thirty minutes, and extended through the whole length of the urethra, but were more severe in the perineum ; he was obliged to rise frequently at night to micturate. The urethra was normal in appearance ; no stricture, and the urine clear, and there was no enlargement of the prostate, so that the disease was considered to be of neuralgic origin, secondary to an old attack of gonorrhœa.

The pains commenced to become less till the middle of March, when a new disease appeared. Two or three days before the patient had indulged in sexual intercourse ; the following day the pains in the perineum returned, and were accompanied by painful

cramps in the inguinal and lumbar regions; twenty-four hours after he felt a burning sensation in the right groin, and discovered some small vesicles there. That same evening the vesicles increased in number to about twenty, and were situated about midway between the spines of the pubis and ilium, were of different sizes, and gradually in a few days dried up, but did not entirely disappear till the twelfth day; there was no anæsthesia or hyperæsthesia in the region of the eruption. The diagnosis of abdomino-genital zona was made, as the lumbar and inguinal regions were affected. Gradually these neuralgic pains disappeared, as well as those in the perineum and urethra; a milky discharge, which first appeared the day after the coitus, ceased toward the end of March. The patient was considered almost well when he again indulged in coitus about the middle of May, and the same evening similar pains as before returned in the urethra, perineum, lumbar and inguinal regions. This time the herpetic eruption was limited to the left groin; there was no anæsthesia or hyperæsthesia. The vesicles dried up rapidly, but the dark crusts remained till about the fifteenth day, when they left behind them small superficial cicatrices. The sensation in the lower limbs remained normal. He had no difficulty in walking, and there were no pains in the lower extremities; only the pain in the urethra after micturition. The patient had several relapses afterward, which were always due to irregularities in diet or sexual indulgence.

The pathogenesis of zona lumbalis seems to be clearly established in this case, for first we have a urethral neuralgia following a case of chronic gonorrhœa; second, during the vehereal act, congestion and excitement of the genital organs, and the result is that after several hours a herpetic eruption appears, attended with severe neuralgic pains. We must also remember that there is an anastomosis between the lumbar and sacral plexuses, and that the lumbar sends several nerves to the external organs of generation.

Another case is recorded by PUECH, in which the zona followed the course of the small sciatic nerve, and occurred in an old man of 65, who had had urethral trouble for many years, and who had been in the habit of passing a sound on himself for six years. The attack of zona followed an attempt to pass a catheter on himself ten days previously, when he had retention of urine and urethral hemorrhage.

These cases of zona secondary to genito-urinary irritation are not limited to men alone, but are also found in women, especially during confinement, and in those who suffer from uterine diseases.

The conclusions he draws are that, in men who are suffering from chronic diseases of the genito-urinary system, as well as in women, zona may occur as a complication, which follows the course generally of one of the lumbar or sacral plexus. The zona resembles herpes genitalis, but differs from it only in its origin. The disease seems to be caused by reflex action.—*La France Médicale*, Nov. 12, 1881.

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EXUDATIVE OR INFLAMMATORY AFFECTIONS:
MULTIFORM, SQUAMOUS, PHLEGMON-
OUS, AND ULCERATIVE.

W. T. ALEXANDER, M.D.

On a simple mechanical method of treating eczema of the legs.—A. REITMAYER applied Martin's rubber bandage in one case of this disease, and was surprised and delighted by the rapid cure which it accomplished.—*Allgemein Wien. Med. Ztg.*, 1881, No. 37, p. 365.

(He had evidently never heard of its routine use in this country for this affection.—REP.)

Conium baths in eczema.—M. CHARTERIS reports two cases of red, itching eczema of the arms and legs treated by baths containing each two handfuls of conium leaves. Both cases recovered completely in two weeks. The patients remained in the bath twenty minutes each day. He advises that the bath-tub be covered with oiled silk, drawn around the neck of the bather to prevent inhalation of the fumes.—*Lancet*, London, Nov. 12, 1881, p. 821.

On exfoliation of the palm of the hand and the tongue in circular patches. (*Exfoliatio areata palmæ manus and exfoliatio areata linguæ.*)—P. G. UNNA describes a benign affection of the palm of the hand and the tongue, which had been previously described by Caspary, Parrot, and others. He first details three cases in which the disease occurred on the hand, and at greater length twelve cases in which it affected the tongue, the so-called "*linguæ hypertrophicæ.*" The latter affection he describes as a benign disease, limited to the tongue, appearing in

the form of circumscribed, round patches, which coalesce and present the appearance of a map. It is kept up by nervous irritation, and is composed of acutely appearing patches, but is, as a rule, an exceedingly chronic, almost painless, epithelial affection of the tongue, having its seat in the uppermost layers of the epithelium, and never attacking the mucous membrane proper. It affects otherwise healthy persons as a rule, and in its first stage, upon a mucous membrane normal in other respects, are seen circular patches, from the size of a pea to that of a twenty-five-cent piece, distinguishable by their color and by the fact that they are not on the same level with the normal membrane. They are usually isolated, but sometimes coalesce, and are ordinarily seated on the edges of the tongue, more rarely near the centre, on both the upper and lower surfaces of the organ. Their edges are usually of a greenish-blue or silvery-white color, and sometimes yellow. He believes the latter color to be the result of secondary dessication. The centres of the patches are red, and usually depressed below the normal level of the epithelium. He denies that their edges are elevated, as has been claimed. They sometimes disappear in one place, after lasting a few hours or days, but reappear in others. They never creep progressively over the surface of the organ. He absolutely excludes syphilis or mercury from the etiology of the disease, but regards anæmia, menstruation, gastric catarrh, and dentition as predisposing causes. In five cases an exacerbation of the affection always immediately preceded the appearance of the menses. In two children the eruption preceded the irruption of the teeth. Unless properly treated, the affection is apt to persist indefinitely. He has obtained gratifying therapeutic results by the local use of desiccating agents, particularly sulphur and sulphuric acid.—*Vierteljahresschr. f. Dermat. und Syph.*, 1881, viii Jarg., Heft. 2 u 3, p. 295.

On psoriasis from borax.—W. R. GOWERS reports three cases, all epileptics, who, while taking at first fifteen grains, later one scruple of borax, three times a day, became affected with psoriasis of the ordinary type, except that the scales were not so thick as usual. The eruptions occurred on the trunk, arms, and legs, on both flexor and extensor aspects. There was no evidence of syphilis in any of the cases, and Gowers is confident that the skin disease was caused by the drug. The eruptions soon disappeared when five minims of Fowler's solution were added to each dose of borax.—*Lancet*, London, Sept. 24, 1881.

On the pathology of psoriasis.—G. THIN confirms the observation of A. R. Robinson, of this city, of the growth of the interpapillary epidermic projections downward into the cutis, causing elongation of the papillæ. He (T.) found, however, that the parts which overlie the papillæ are much thinner than in the normal epidermis, and also that the horny layer is much thicker in the diseased than in the healthy skin. On studying the

epidermis covering the apices of the papillæ he found that the layer of prickle cells was very much reduced in depth, and that the cells themselves were undergoing degenerative changes. The stratum lucidum, although still present, had lost its definiteness, and above it he found a great thickening of the horny layer. The disease he thus found to coincide with a diminished and abnormal "prickle-cell layer" immediately above the papillæ. It is in consequence of the diseased condition of this layer that we find an unusually rapid formation of an abundant, but imperfectly developed horny layer.

As regards the excessive development in the deep interpapillary projections, his preparations bore out the descriptions of Neumann and Robinson. The changes found in the vascular tissues he regards as the result of the irritation set up by an unhealthy epidermis.—*British Medical Journal*, July 30, 1881, p. 140.

Rhus poisoning.—W. A. HARDAWAY, in a clinical lecture, speaks in praise of the treatment of this affection by sulphate of zinc. He advises that a solution of half an ounce in a pint of water be applied in the form of a lotion to the skin every hour during the day and several times during the night. Under this treatment he says that relief is felt in a few hours to the itching and burning, and in many cases the eruption is aborted in two days. In no case has he found it necessary to prolong this treatment beyond four or five days. He recommends the same treatment in other acute affections, in eczema, erysipelas, etc.—*St. Louis Courier of Medicine*.

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HYPERTROPHIES AND ATROPHIES.

F. B. GREENOUGH, M.D.

Pigmentation of face and other parts.—Dr. CHAMPNEYS, in an article on pigmentation of the face and other parts, especially in women, regards the following causes as being responsible for this condition—pregnancy, abdominal tumors, menstruation, age, disease as Addison's, cachectic conditions, etc., and nervous influence.

He quotes eight cases from his note-book, in all of which menstrual irregularities existed, if they were not the most prominent symptom. These different causes of pigmentation are exemplified quite fully, though concisely, by cases quoted. Under the head of nervous influences he mentions instances of the blanching of the hair from sudden emotions, as fright, terror, etc., and also some of the opposite nature—that is, where pigmentation followed fright and even emotion falling short of grief and terror. He quotes three cases of steorrhœa nigricans, where pigment is secreted from the free surface of the skin.

From Erasmus Wilson's table of causes the predisposing causes for twenty cases of pigmentation are given as nervous debility; in thirteen, nutritive debility; in three, an assimilative debility; in three, remote predisposing causes; pregnancy and uterine derangement in nine; nervous shock in six.

Various experiments by well-known observers in the field of comparative anatomy are recorded, amongst them Pouchet who is quoted in full. His conclusions may be briefly stated to amount to considering the chromatic function to depend on an expansion or contraction of the chromoblasts; in the former case a deepening of color takes place, in the latter the shade of color becoming lighter. Over this power of contraction and expansion he con-

siders that the nervous system presides, or, to quote him : "The nerves are the conductors of this reflex action ; they can produce expansion or contraction of the chromoblasts."

Some of the general conclusions arrived at are as follows :

"Thus, as far as these animals are concerned, the influence of the vascular system on pigment is eliminated. As far as human beings are concerned we have proof that various causes effect the pigmentary condition—age, sexual influences (especially menstruation and pregnancy), emotions (especially that of fright), diseases of various kinds, including many in which the nervous system is involved, fatiguing and debilitating influences of various kinds. Whether the nervous system is or is not the first offender, the pigmentary changes are most probably produced through the nerves distributed to the part affected.

"The suddenness with which violent emotions may produce their effect can hardly be explained by any other supposition than by the direct action of the nervous system. Many other causes, such as various diseases, especially changes in the sexual organs, which may at first seem to be separated from the purely nervous causes of pigmentation, are not really so, for their intimate association with the nervous system confirms the view of the essential presidency of the nervous system over pigmentation."—*St. Bartholomew's Hosp. Reports*, London, 1879, xv, p. 233.

[It is a pity that in such an exhaustive article as this on the subject of pigmentation, the rôle which continued capillary hyperæmia plays as a factor should not be referred to. All that is said on the subject is :

"In 1869, Herring stated his belief that pigment cells are affected through the blood-vessels, that is, through the vaso-motor nerves." On the other hand, from experiments on animals it is claimed that the influence of the vascular system on the pigment cells is eliminated. These experiments and observations on animals, especially fish and reptiles, are extremely interesting, but many of them, such as those showing the changes in color, form a change of surrounding media, as the bottom of the river in the case of fish, and the object on which a chameleon is resting, do not seem to present much analogy to the deposit of pigment in the human skin.

That this deposit does result from continued capillary hyperæmia, is shown to us every day in such well-known examples as that of sunburn, the dark patch left after sinapisms or blisters, and after the use of croton oil ; in cases of chronic inflammation of the cutis, especially the syphilodermata, where by pressing out the blood from the capillaries we can see the yellowish-brown spot of pigment ; chronic eczemas of the lower leg, etc., etc.

It is true that these congestions may be said to depend on the vaso-motor system, but surely the active factor is the stasis or partial stasis in the capillaries and the consequent deposition of pigment ; and in many cases of pigmentation of the skin at least, this seems a more rational explanation of the fact than an assumed expansion and contraction of the chromoblasts.—*REP.*]

Myxœdema.—Although the occurrence of the above term in dermatological literature is of comparatively recent origin, we must go back to 1873 to get the history of this affection. On Oct. 24th of that year, Sir WILLIAM GULL brought before the *Clinical Society of London* observations on five cases, illustrating what he described as “a cretinoid state, supervening in adult life in women.” These cases were reported by him as being a form of disease not heretofore described. It was not until 1877 that the name myxœdema was proposed for the affection, it being suggested by Dr. WILLIAM M. ORD in a paper read before the *Royal Medical and Chirurgical Society of London*. In this paper five other cases are reported, two of them very fully and one resulting fatally : an autopsy was obtained. As a result of the *post-mortem*, Dr. Ord was induced to christen the heretofore unrecognized disease with the name of myxœdema. There is certainly a marked similarity between the cases reported by Ord and those of Gull’s.

They all were women in or near middle life, and the chief characteristic of the disease was an œdematous appearance of the cutis, especially marked in the face and hands, and a general loss of muscular power, with difficulty in articulation and a decided slowness of the mental faculties. Ord’s fatal case toward the latter part of her life developed symptoms of Bright’s disease, there being true œdema and albuminuria. The autopsy was most carefully made, and portions of the cutis were examined both chemically and microscopically. The tissues examined gave the reaction of mucin, and the connective tissue seemed to be swollen or hypertrophied into a gelatinous material. Dr. Ord says : “The suggestion is to the effect that a jelly-like state of the fibrillar or white element of connective tissue is the essential and common condition of these several cases, and that nervous disorder and vascular change are definitely consequent thereon.” In a footnote it is stated that, since the reading of the paper, skin from œdematous bodies had been submitted to the same processes and no increase of mucin had been found. In the meanwhile a series of similar cases had attracted the attention of an entirely independent French observer in the province of Brittany.

Dr. MORVAN, de LANNILIS in the *Gazette Hebdomadaire*, August 26, 1881, gives the first of a series of four papers, entitled *Contribution à l’étude de Myxœdème*, in which he reviews the whole subject, and reports fifteen cases of his own. He begins by giving a letter which he addressed to Charcot on November 26, 1875, in which he stated that he had observed in Brittany several cases of a disease which he did not think had yet been described. He says : “It is confined to the female sex, at least up to the present time I have not seen it in the male. It is characterized by anasarca, and by an incomplete general paralysis, without muscular atrophy, and without loss of the mental faculties, and not due to any cardiac or renal affection. The swollen condition of the face, combined with a certain slowness of speech, and a hoarseness of

the voice, is pathognomonic. The œdema is especially marked, though never excessive, in the face, hands, and legs; it never disappears entirely, but varies considerably, especially in the face, the features of which are more or less enlarged." He goes on to describe the partial paralysis, which he says is never sufficient to prevent locomotion, but makes it slow and renders running impossible.

His cases, which up to that time were eight, were all women, and six of them beyond middle age. They were very sensitive to cold, which, moreover, aggravated the loss of muscular power. Beyond the fact of sex and age he had not been able to accuse any cause of the trouble, and with the exception of a temporary improvement during the exhibition of strychnia in one case, and a decided amelioration under treatment by electricity in another, he had found no result from the various remedies employed. Not receiving any answer from Prof. Charcot, he wrote in the same manner to Dr. Verneuil, who replied, that in the opinion of himself and several of his colleagues the cases must have been due to chlorosis. Charcot did, however, answer his note later, and informed him that he had never met with cases of a similar nature, and advised him to publish his observations, which he now does, having fifteen in all. Sixteen other cases bring the number up to thirty-one. These are five of Gull's, five of Ord's, three of Charcot's, one of Charcot and Thaon's, one of Hammond's, and one reported by MM. Bourneville and d'Olier. Of these, four were males. He quotes largely from Ord, especially in his remarks on the pathological anatomy of the disease, as Ord furnishes the only case where an autopsy was obtained. He admits that it is a pity that in the only *post-mortem* made, the case had shown symptoms of Bright's disease before death.

He concludes that "the changes found in myxœdema are due to a gelatinous infiltration which gives all the chemical reactions of mucus, and has all the microscopical characteristics of mucous tissue." He sums up that "myxœdema is a neurosis of the central nervous system affecting only the motor nerves, both of animal and organic life, which are paralyzed, and consequently leaving intact that part of the nervous system appertaining to the mental faculties and the nerves of sensation."—*Gaz. Hebdomadaire*, Paris, 1881, n. s. xviii, pp. 542, 557, 573, 590.

At a meeting of the *Medico-Chirurgical Society of Edinburgh*, January 5, 1881, Dr. CLOUSTON showed a very marked case of myxœdema in a man aged fifty. The disease was of eight years' standing, and showed "the cretinoid expression of the face, the thickened, boggy, bulbous skin; the slow, dragging walk; the thick, drunken speech; the spade-like hands, and the feeling of numbness all over the body." In this case the mental faculties were affected, as he was slow in all his mental processes, taste was impaired, and smell almost abolished. Dr. Clouston regarded the name as unfortunate and premature, as it was another instance of a disease being ticketed with a name from mere outside appear-

ances. He regarded the disease as a trophic neurosis, and thought that its seat and origin were in the central nervous system.—*Ed. Med. Four.*, 1880-81, xxvi, p. 743.

Dr. A. CLIFFORD MERCER read before the *Syracuse Medical Association*, Feb. 15, 1881, a paper in which he gives a résumé of the literature of this subject up to date, and exhibited sections of myxœdematous structures under the microscope. Other cases reported by Andrew Clark, Lloyd, Heron, Greenhow, Hadden, and Goodhurst are referred to, and Dr. Mercer concludes that "until the results of further investigations are known, we may consider myxœdema a substantive disease having a trophic neurotic origin, resulting in an increase of mucin cementing material of connective tissue in all parts of the body. That its phenomena are due to the partial insulation, compression, or destruction of the more essential elements of structure in the various parts by the mucoid overgrowth of the connective tissue; and that the disease slowly, but inevitably progresses to a fatal termination in spite of all treatment.—*Medical Record*, New York, 1881, xix, p. 421.

Dr. W. A. HAMMOND reported a case of myxœdema at the meeting of the *American Neurological Society* held on June 16, 1880, and gave a summary of what was known on the subject up to that time. Naturally he was more interested in the mental and nervous symptoms than in the cutaneous manifestations, and in his case the former seem to have been more marked than in the average of previously reported cases. He concludes: "In the cases in which *post-mortem* examinations were made (those of Dr. Ord), the mucoid deposit was found in abundance throughout the brain, as well as in almost every other part of the body, so that there is no improbability in the suggestion that the morbid process may begin there. At the same time the padding to which the nerves are subjected must certainly interfere with their healthy function, and, hence, I think it quite reasonable to hold the view, as I do, that the phenomena of myxœdema are the result both of central and peripheral disturbances."—*Neurological Contributions*, New York, 1881, vol. 1, No. 3, p. 36.

A very excellent résumé of the literature and history of myxœdema is given in an editorial article in the *Boston Med. and Surg. Journal*, which concludes: "This subject is one which deserves and probably will attract further attention, the advantages in the discussion so far being decidedly with those who regard myxœdema as a distinct and independent disease."—*Boston Med. and Surg. Journal*, 1882, vol. cvi, No. 10, p. 233.

[The fact that myxœdema as a distinct disease has not yet been accepted by the German authorities is, perhaps, significant; all the cases reported, with the single exception of Dr. Hammond's, being of English or French origin. There most certainly does seem to be a marked similarity of decidedly unusual symptoms grouped together in these cases, but even if it should be accepted, it seems as though it must prove of more interest to the neurologist than to the dermatologist.—REP.]

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II.

SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS, ETC.

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Syphilis in old persons.—QUINQUAUD has made an exhaustive study of the course taken by syphilis when it occurs in persons in advanced life. He finds that the incubation and duration of the chancre, as well as of the lymphatic ganglionic engorgement, are longer than in middle life. It is the same with the later symptoms, and as Quinquaud says, "Syphilis acquired after the age of sixty is a drama, the successive acts of which are slower in their development than those of syphilis acquired in early life."

As to the prognosis of syphilis in old persons, the secondary and tertiary manifestations may be as severe as, or even more severe than, those of youth or adult age. Sigmund asserts that nutrition being less active in the aged, syphilitic manifestations should be less severe, but Quinquaud's experience shows that

visceral and other lesions of extreme gravity may occur in syphilis contracted in such persons as well as in the young.

As to the localization of the lesions, these are different from those ordinarily observed in the adult. After the age of seventy the pharynx is rarely affected, the scalp and hair are commonly spared, and the gums are more apt to escape the effects of mercury.

Two marked characteristics display themselves in the early syphilitic eruptions of the aged : 1. Their resistance to therapeutic measures ; 2. Their tendency to relapse.

Cutaneous gummata are found in the aged during the early period of syphilis, just as they are sometimes found in the adult. They may occur, 10 to 15 at a time, scattered over the body, are from pin-head to small pea size, partly buried in the skin, with very little color at first, and tend to break down in the centre, leaving a little crater-like cavity or a crust, which often causes them to be mistaken for pustules.

Early malignant syphilis is not very rare in old persons. When it does occur it is extremely rebellious to treatment and relapses are common.

Nervous disturbances of a severe character may occur even at an early period in the evolution of the disease. Delirium and other intellectual disorders, even aphasia, are most frequent. Paralysis may occur, but in the earlier period of the disease these affections are amenable to the mixed treatment. Nervous troubles occurring at a later date are very rebellious to treatment.—*Annales de Dermatologie et de Syphiligraphie*, Paris, 1881, n. s. sér., t. 2, p. 502.

A constant nervous disturbance in the early eruptive stage of syphilis.—FINGER has observed in a series of carefully noted cases which have come under his observation, that in every instance a decided increase in cutaneous and tendon reflex excitability occurs. This is noticed just before and during the earlier stages of the eruption, and is followed by a corresponding decrease in reflex excitability, even in many cases running considerably below the normal. The natural condition of the skin and tendons in this respect is reached only very slowly, often not until weeks have elapsed from the disappearance of the exanthem. Moreover, relapses of the eruption are followed by decrease of excitability as before.—*Vierteljahresschrift für Dermatologie und Syphilis*, viii Jahrg., 1881, s. 255.

Excision of a chancre forty-eight hours after its appearance.—MAURIAC gives the following clinical contribution to the question of the excision of chancre.

A medical student after indulging in a connection with a woman in full tide of syphilis, watched himself sedulously from day to day, expecting the appearance of a chancre. On the twenty-ninth day he found two suspicious erosions on the præputial mucous

membrane, which he showed to Mauriac forty-eight hours later, when they were pronounced by him to be chancres and excised. The wounds healed kindly, but ten or twelve days later a new erosion, with some neoplastic infiltration, was observed adjoining one of the cicatrices. Later the inguinal glands began to swell, and several indurated patches made their appearance in the balano-præputial groove (sixty-third day after the appearance of the excised papules). An examination made on the seventy-first day showed several opaline mucous patches in the buccal cavity about the anterior half-arches.

The patient then began to take mercury, which caused the indurated lesions about the penis to disappear, but the mucous patches persisted up to the ninety-third day. No other symptom of syphilis had shown itself at this time, the date at which Mauriac's report was made.—*Annales de Dermatologie et de Syph.*, Paris, 1881, n. s., t. 2, p. 532.

Early syphilitic affections of the subcutaneous cellular tissue.—MAURIAC has just completed one of those minute and laborious studies in the department of syphilology for which he is noted. In a series of papers, beginning in the *Annales de Dermatologie et de Syphiligraphie*, vol. i, n. s., 1880, p. 418, and ending in vol. ii, 1881, p. 471, he studies the early syphilitic lesions of the connective tissue, arriving at the following conclusions :

1. In the subcutaneous connective tissue, as well as in other organs and tissues of the economy, various lesions may occur almost immediately after the appearance of the initial lesion, and during the most active stages of the virulent period. This is contrary to the views formerly held, which regarded lesions of these structures as essentially among the late manifestations of syphilis.

2. These early lesions, like the late ones heretofore described by authors, take the form of neoplastic, tumor-like, or diffused morbid growths in the connective tissue.

3. Taking the ordinary appearance of these tumors as a basis of classification, the early subcutaneous gummata may be divided into three categories.

The first of these, which has never heretofore been described, Mauriac calls "syphilitic erythema nodosum." It is characterized by the simultaneous generalization, in an eruptive form, of various neoplasms on different parts of the body, chiefly on the lower limbs, less frequently on the arms. The eruption is often preceded and accompanied by febrile symptoms and rheumato-neuralgic perturbations seated in the localities where the eruption is about to make its appearance.

Among these neoplasms, which are almost as much cutaneous as subcutaneous, there are some patches of true erythema nodosum, subcutaneous tumors, extensive effusions of a phlegmonous character. Resolution, however, is the rule. Whatever may be its form, its extent, its intimate connection with the skin, and the acute character of its symptoms, the neoplasm always remains solid, and never undergoes necrobiotic softening.

4. In the second category of cases the patches, the nodosities, the tumors, the infiltrations, occur singly and isolated, without any general eruptive character. They appear insidiously and are indolent. They tend spontaneously to resolution, and their duration is generally brief. Sometimes they soften and form subcutaneous collections of fluid, but the skin covering them resists the disease action, and absorption takes place without suppuration and without ulceration.

5. In the third category are included neoplasms of all forms, but ordinarily exclusively subcutaneous during their formative period, and which quickly tend to suppuration. The rapidity of their progress is the most characteristic point about them. The superjacent skin is always involved, and they are often the beginning of dermatoses resembling ecthyma in appearance. Two varieties may be mentioned according to their course, duration, and the gravity of the lesions which they produce. The first, which is benign, is most common; it may get well spontaneously in a month or so, and much more quickly under the use of iodide of potassium. The second variety, which is malignant, only differs by its occurrence early in the evolution of the disease from the worst form of tertiary gummata. It is extremely rare. The lesions are evolved slowly, and show no tendency to resolution. They suppurate and ulcerate, and are very refractory to iodide of potassium, which neither prevents their appearance nor cures them.

6. The average date of appearance of these early subcutaneous neoplasms is as follows: (a) Erythema nodosum-like lesions, four months after the appearance of chancre; (b) circumscribed subcutaneous and cutaneous neoplasms which tend to resolution, the fifth month after the appearance of the chancre; (c) for those early neoplasms of ulcerative tendency, nine months from the first appearance of the chancre. The shortest interval which has been observed between the appearance of the chancre and that of the neoplasms under consideration is two months; the longest, fifteen months. Coincidentally with these lesions all the various lesions of early active syphilis may be at times observed.

Syphilis of the liver, syphilitic hepatitis. CHVOSTEK, after an historical introduction accompanied by a full bibliography of the subject, describes syphilis of the liver from every point of view. In his experience it is one of the commonest visceral affections both in hereditary and acquired syphilis, and occurs as a late symptom. Pathologically syphilis manifests itself in the liver: (1) either in the form of amyloid degeneration, due to the general syphilitic cachexia; (2) in the form of perihepatitis, usually accompanied by decided thickening of the capsule of the liver, leading to adhesion between this and the liver, and to perihepatitis; (3) in the form of hepatitis. The result of this process is the considerable increase in connective tissue, and formation of

shrinking and contracting cicatrices. Two forms of syphilitic hepatitis are generally described : the diffused and the gummatous.

The symptoms of syphilitic hepatitis are often so insignificant as to rouse no suspicions of the presence of the disease during the patient's lifetime. In congenital syphilis of the liver this organ is more or less enlarged, hard and smooth on the surface. In acquired syphilis, however, the liver is frequently not enlarged, and so far from being smooth shows a surface irregular with walnut- to hen's-egg-sized protuberances, between which are deep sulci. Sometimes the process goes so far that almost independent portions of the liver can be perceived, which are attached to the main portions of the organ by cicatricial bands. In some cases adhesion takes place between the liver and the walls of the chest and abdomen, and then this organ does not move with the respiratory movements.

Pain in the hepatic region is one of the most constant symptoms. It may be localized at one point or may be diffused, and is sometimes dull and heavy, at other times sharp and intense. It is made worse by pressure, but does not radiate to the shoulder or elsewhere. It is worse in the early stages of the disease, but diminishes or disappears later. The intense pain is connected with perihepatitis.

While the syphilitic process in the liver is recent a rubbing sensation can be felt and heard during respiration.

Now and then compression and obliteration of numerous branches of the portal vein, or even of the vein itself, occur, leading to symptoms of damming up in the neighboring parts, such as ascites, occasional enlargement of the spleen, bleeding in the stomach and intestines, the development of collateral circulation, etc. Ascites is observed only in those cases where the liver is shrunken, excepting now and then when it is very slightly enlarged, or in the case of infants dead-born or dying soon after birth. The enlargement of the spleen accompanying syphilitic liver is usually due to independent syphilitic disease, not commonly to the affection of the portal circulation just mentioned, though this is sometimes the case.

According to Gubler and Leudet a transitory and slight icterus occurs in the earlier periods of syphilis. The cause of this has been variously ascribed to hyperæmia of the liver, to swelling of the neighboring lymphatic glands, to a catarrhal affection of the ducts, and to an affection of the liver itself. Most patients with syphilis of the liver have an earthy look, and occasionally a bronzing of the skin has been observed.

Gradually increasing gastric disturbance is noted in many cases ; others show progressive cachexia and albuminuria, with tube casts as the result of accompanying parenchymatous or amyloid disease of the liver.

The diagnosis of syphilis of the liver depends more upon the history or presence of other syphilitic manifestations of an unquestionable nature, than upon any peculiar symptoms presented by the lesion itself.

From cancer it is distinguished by the usually concomitant albuminuria and enlargement of the spleen, as well as the great irregularity of general form and the more sharply defined character of the protuberances, and their frequently stationary condition for considerable periods.

From cirrhosis, syphilis of the liver is distinguished by the history or presence of other syphilitic symptoms: when a history of alcoholic excess can be excluded, when larger irregularities can be felt over the surface of the liver, and when the shape of the diminished organ varies more or less from that observed in cirrhosis (*e. g.*, the left lobe is less diminished than the right).

Syphilis of the liver is a chronic disease often lasting for years, excepting the hereditary variety, where death occurs within two or three months. In Chvostek's cases the affection lasted from four months to a year or more.

The prognosis of syphilis of the liver is very unfavorable: of Chvostek's seventeen cases but one recovered; the others all died, usually from some complication. If taken in hand at an early date, however, Chvostek thinks the prognosis would be more favorable.

The treatment of syphilis of the liver is that of late syphilis: first, iodide of potassium; and later, mercury.

Chvostek adds a description of twelve cases coming under his observation.—*Vierteljahreschr. f. Derm. u. Syph.*, viii Jahrg., 1881, p. 325.

Diseases of the kidneys dependent upon syphilis.—

Dr. E. WAGNER says that although kidney disease as a result of syphilis is unusual, yet it is not as rare as has been supposed. In 9,000 autopsies Wagner found 63 cases of kidney trouble. Of these 8 were acute Bright's disease, 4 chronic, 7 granulated kidney, 6 atrophy of one kidney, 35 amyloid degeneration, and 3 syphiloma. Speiss, in 220 autopsies of syphilitic cases, found pathological changes in 147. Only 7 had gummatous interstitial nephritis. Of 10 cases of congenital syphilis with diseased kidneys there were 3 each of parenchymatous nephritis, amyloid nephritis, and infarction, with 1 of simple interstitial nephritis. Bamberger found 49 cases of syphilitic disease in 2,340 cases of acute and chronic Bright's disease. A. Beer describes very fully the various anatomical conditions in the kidneys of syphilitic persons: 1. Small circumscribed nodular formations (gummatous tumors) in otherwise normal or differently diseased kidneys. 2. Simple interstitial hyperplasia, mostly irregular, with the formation of cicatrices; rarely scars in otherwise normal tissue. 3. Diffuse cellular hyperplasia of the interstitial tissues, mostly with lardaceous degeneration of the vessels and manifold atrophies of the new formation, as well as with peculiar parenchymatous changes. These were particularly small fatty deposits; rarely this form without lardaceous degeneration. 4. Purely parenchymatous affections. Without other aids to diagnosis, only the first and third

of these forms can, according to Beer, be regarded as characteristically syphilitic.

In Wagner's study of these diseases he divides his cases into several categories: 1. Under the head of acute Bright's disease he gives the histories of three cases where this affection was either observed in patients under the full influence of the early stages of syphilis, or where the symptoms disappeared under the use of antisyphilitic remedies, and follows these with five more cases where *post-mortem* examination of patients who had showed symptoms of syphilis during life revealed parenchymatous nephritis with hemorrhage, etc. 2. Under the head of subacute or chronic Bright's disease, Wagner gives four cases similar to those in the first division, except that the autopsy showed in each case the second stage of Bright's disease. 3. Under the head of granular kidney seven cases are included, in four of which a microscopic examination was made. General characteristic appearances were not noted; in particular there was no constant arterial affection. The coincidence of the syphilitic symptoms and the kidney disease appears to have been made out in each case.

Under the head of unilateral atrophy of the kidney six cases of constitutional syphilis are given, where marked contraction of one kidney was found with compensatory hypertrophy of the other, which was either normal or showed amyloid degeneration. While other causes might have been adduced for the atrophy in these cases, syphilis was the most likely. Weigert observed the same condition in two instances, and found arteritis obliterans as first described by Heubner in syphilis. Macroscopically the kidneys were quite smooth; microscopically the changes were closely similar,—extreme disturbance of the cortical canaliculi, sometimes with entire, sometimes with contracted glomeruli in a stroma diffusely infiltrated with small cells.

Wagner observed thirty-five cases of amyloid degeneration of the kidney, and gives brief notes of the most interesting. Tuberculosis and also amyloid degeneration of liver and spleen were present in many of these cases. Some cases were cured. Finally, Wagner gives several cases of syphiloma, one of which had apparently been cured by treatment. He adds to this a number of references. The article is a very valuable one, and is carefully worked up. — *Deutsches Archiv für Klinische Medizin*, 28ten Bd., p. 94.

The spleen in syphilis.—In order to be able to form a personal opinion about the liability of the spleen to be affected by the syphilitic dyscrasia, Dr. BLOCH has examined the *post-mortem* records of the City Hospital of Copenhagen (Denmark) for fifteen years, viz., from 1866 till 1880, both included. He has collected 154 cases of *post-mortems* of children who had died with hereditary syphilis. In 96 of these the spleen was healthy. He gives the complete list, with details, of the fifty-eight cases in which the spleen was found in pathological conditions. These

were hyperplasia, simple (14 cases), or combined with increased density of the tissue (31 cases), or with greater softness of the tissue than in the normal spleen (10 cases). Further, there was one case of infarctus, one of fibrinous exudation on the serous membrane, and one of thickening of the capsule and adhesion to the neighboring organs. Besides this he found in ten cases of hyperplasia fibrinous exudation on the surface of the spleen, four times thickening in different places of the capsule, and once adhesions to the contiguous parts. In eight cases there were found miliary tubercles, but always combined with tuberculosis of other internal organs.

Next Dr. Bloch examines to ascertain if the changes reported are referable to syphilis itself or whether they may as well be due to other diseases which occurred in individuals tainted with syphilis. He excludes three cases in which there were found tuberculous nodules in the spleen as part of a general tuberculosis. The great frequency with which hyperplasia is found warrants him to look upon it as a manifestation of the syphilitic dyscrasia, as described by Virchow and others.

On the other hand, the author does not think that the evidences of perisplenitis (fibrinous exudation and adhesion to neighboring organs) which were found in some cases are attributable to syphilis, since serous membranes nowhere else are found affected by syphilis.

The thickening of the capsule, he thinks with Virchow, is to be ascribed to present or past inflammation in the organ. He cannot determine from the report if the infarctus found in one case was a cicatrix as described by Virchow.

In no case of the 154 was there mentioned gummatous tumors, nor amyloid degeneration, and among 44 adults who had died in the course of syphilis during the same period, he found only three cases with amyloid degeneration, and none with gummatous tumors. These are indeed exceedingly rare in the spleen.

Dr. Bloch, in accord with Trapp, but in opposition to most other writers, thinks that the amyloid degeneration has nothing to do with syphilis, but when found in persons suffering from that disease is only due to long-continued suppuration.

Of the 44 adults suffering from syphilis, the spleen was found perfectly healthy in 14 cases; hyperplasia in 27 cases,—11 times the soft variety, 16 times the hard. Together with the hyperplasia there was twice found thickening of the capsule in different places, and four times adhesions to the neighboring organs.

The hyperplasia then has been found in 61.4 per cent. of the cases of adults with acquired syphilis, while it was only found in 36.4 per cent. of the cases with hereditary syphilis. This seems to prove that it does not appear very early in the development of the disease.—Abstracted by Dr. H. J. Garrigues, from *Hosp.-Tidende.*, Copenhagen, vol. ix, Nos. 2 and 3, Jan. 11 and 18, 1882.

The temperature of little children with syphilis.—Dr.

HOLM has taken the temperature in 23 children, 17 of whom had congenital and 6 acquired syphilis. Among those with congenital syphilis three showed for weeks a marked subnormal temperature, sinking sometimes to 35° C. The other children had also more or less subnormal temperatures. In five patients it was impossible to judge of the influence of syphilis on the temperature of the body, because inflammatory processes brought it up.

Of the six with acquired syphilis, one had sometimes an evening temperature of more than 38° C. The others had a normal temperature. Thus, there is a marked difference in regard to the influence of temperature between the congenital and the acquired form of syphilis. Likewise the difference between children and adults in regard to temperature is noticeable, syphilitic fever being frequent in the latter.

In children with congenital syphilis a great difference was found between the morning and evening temperature, as much as 3.2° C., and the latter was usually lower than the former. In children with acquired syphilis this relation was, as a rule, reversed.

The subnormal temperature is not characteristic of congenital syphilis. Holm found it likewise in other children suffering from infantile atrophy, furunculosis, and pemphigus. The low temperature is only due to the general marasmic condition.—Abstracted by Dr. H. J. Garrigues, from *Hosp.-Tidende*, Copenhagen, series ii, vol. vii, pp. 21, 41.

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SYPHILIS OF THE EYE.

EDWARD S. PECK, M.D.

Monocular mydriasis and paralysis of accommodation due to syphilis.—ALEXANDER adds seven to twenty-eight cases of this group of symptoms, published in 1878 in the *Berlin. klin. Wochenschr.*, and confirms the following conclusions deduced from his first series, viz. : (1) monocular paralysis of accommodation, associated with mydriasis is syphilitic in a very large majority of cases. (2) It is one of the latest manifestations of syphilis. (3) It is incurable. (4) It is always cerebral, and consequently (5) is the prodrome of mental disturbances. Of the thirty-five cases, twenty-five (72 per cent.) were syphilitic, five (14 per cent.) were of doubtful specific character, and five were traceable to other sources. No case recovered. In addition, ten of the patients with specific origin gave evidence of mental disturbances of different degrees of gravity, while one died in an insane asylum.—*Deutsche med. Wochenschr.*, Berlin, 1881, vii, p. 562.

Influence of gout and syphilis upon operations for cataract.—GALEZOWSKI, of Paris, gave the details of three cases of suppuration of the globe consecutive to good cataract-extractions, and which occurred without appreciable cause, but in which there had been an old syphilis. The gouty diathesis predisposes to ocular hemorrhages. On the other hand, Liebrecht, Landolt, and Carreras, have obtained complete successes among syphilitics, and this after eyes had suffered from trauma.—*Cong. périod. internat. d' Ophthalmol., Compte-rendu*, 1880, Milano, 1881, vi, p. 13.

Syphilitic iritis.—Dr. STURGIS, of New York, emphasizes in a clinical lecture the importance of differentiating between an early and late iritis, without which confusion may easily arise.

The disease belongs to the group of secondary symptoms; most works assert its inception as late as the third month after the initial lesion. In very many cases it occurs, as in the one of the author, much earlier, and may be concomitant with it. The iritis accompanying tertiary symptoms is much more serious, and is usually the forerunner of lesions of the retina and choroid.—*Medical Bulletin*, Phila., 1881, iii, p. 251.

Syphilitic iritis.—Dr. WEBSTER, in a clinical lecture at the College of Physicians and Surgeons, N. Y., employs iodide of potassium in drop doses of a saturated solution, but not until a week or longer has elapsed after cessation of mercurial inunctions.—*Medical Record*, N. Y., 1881, xx, p. 213.

A case of iritis syphilitica treated with cascara amara.—REULING reports a case in which a patient had specific iritis of the right eye, and general nummular psoriasis. There were multiple post-iritic adhesions, and a large condyloma iridis, pointing from the anterior endothelial layer of the iris, and almost touching Descemet's layer of the cornea. The initial lesion was six months old. Conjointly with instillations of a four-grain solution of atropia, forty-drop doses of cascara amara were given three times a day. In three days the iritic pain was markedly diminished, aqueous humor clearer, and the exanthem less pronounced. On the fifth day the pointed adhesions were detached, the broader ones were normal, and the condyloma was paler and smaller. After six weeks of continuous treatment only one adhesion remained, and the habitat of the neoplasm was marked by an atrophied and slightly discolored spot in the stroma of the iris. The exanthem gradually disappeared, so that in ten weeks the patient was free from all cutaneous and iritic symptoms.—*Therapeutic Gazette*, Detroit, 1881, ii, p. 207.

A contribution upon the inoculation of syphilis in the iris and cornea of the rabbit.—HÆNSELL had demonstrated the thesis that tuberculous substances injected into the anterior chamber of the eye of all animals produced tubercles of exact identity with those seen in the human iris.

Proceeding in this way with syphilitic products, he selected a rabbit, and injected into each anterior chamber the thin fluid of a suppurating knot lying over the manubrium of the sternum of a syphilitic woman in Sigmund's clinic. Although the virus was absorbed on the fourth day, the animal fared badly, and died on the nineteenth day of an acute enteric catarrh. The autopsy, made with special regard to the eyes, developed nothing of a syphilitic character. He injected similar virus into the right anterior chamber and the left cornea of a second rabbit; the virus was apparently absorbed on the fourth day; in twenty-five days iritis resulted, with opacity of the aqueous, and the usual pericorneal zone of vascularity. The iris was grayish red, and swollen in meridional folds; and there were posterior synechiæ. On the ninth day of the iritis (thirty-fourth day after inoculation), four small grayish knots appeared upon the inferior and inner border of the pupil. These were of slow growth, and remained for many weeks of the size of half a barley-corn. The original white knot was covered throughout by a fine network of vessels, detectable only with the convex lens. In the third month these knots became obscured from view by a thick progressive pannus,

running from border to centre. At the puncture-point of the Pravaz syringe an abscess resulted, secreting a small quantity of thin pus, but which never progressed to a necrotic perforation of the cornea. In the fourth month after inoculation the limbus corneæ and adjacent conjunctiva and sclera were pushed out by several vascular knots of good size, which on anatomical examination proved to be gummy tumors of the ciliary body. On the eye, inoculated in the parenchyma of the cornea, several small knots developed in six weeks, which were covered by a very fine and thick network of vessels. The animal slowly emaciated, and died in six months. During life, small bean-sized tuberosities (comedones) could be felt over the liver and abdomen; but with this exception there was no evidence of syphilitic infiltration. At the autopsy the lungs and liver were found to be traversed with small, hard knots, which were built up chiefly of round cells, and polynucleated epithelioid cells, with here and there a giant cell. Microscopical examination of the cornea, iris, and ciliary body of both eyes revealed the same products, as were found after the inoculation of tubercle. Another rabbit, inoculated with the *products of inoculated syphilis*, furnished the same chronological series of symptoms; while the revelations of the autopsy were the same micro- and macroscopically.

On the supposition of a doubt as to the syphilitic nature of these iritic and corneal products of inoculation, H. inoculated portions of mucous patches taken from the anus of a syphilitic woman (confessedly the most infectious form of syphilis) into the anterior chamber of both eyes of two rabbits. Severe keratitis and iritis supervened in a short time, as might be inferred from the well-known difficulty of preserving this material free from sepsis. One animal died very soon, and the iris-knots were found to be the same here as above described. In the two other eyes, the inflammatory appearances rapidly subsided, so that the cornea and anterior surface of the iris soon became transparent. In ten days every trace of iritis had disappeared. In thirty-one days after inoculation, however, a typical secondary (recurrent) iritis set in, with pericorneal injection, opacity of the aqueous, infiltration, and the grayish-red color of the iris. At this time three or four highly vascularized knots appeared on the inferior half of the iris near the irido-ciliary angle. These remained without change as to size for three months, when the animal died. Upon section, the liver of one rabbit showed bean-sized knots, made up of tolerably large epithelioid cells, and some giant cells with intervening reticulum. The iris and ciliary body had knots, giving a structure akin to tubercle.

A sixth rabbit was inoculated (in the anterior chamber of the eye) with fragments of *sclerosed tissue*, cut from the prepuce of a syphilitically infected man. A seventh rabbit was inoculated with an indurated chancre. Both developed small white spots of pigmentless atrophic iris-tissue—the former in the third month, the latter in the first month after inoculation.

These experiments showed a remarkable similarity between the inoculated syphilis of animals, and the syphilitic affections of man. After a period of incubation of about one month, there was developed a subacute iritis, followed in several days by highly vascularized knots, like the gummata iridis of man. These must be regarded as syphilitic papules, since they preserved in every case a certain size and shape. The larger gummata of the ciliary body of the second rabbit made the nearest approach to human gummy tumors on account of their comparatively late development and size.

H. asserts the following differential points between the inoculation of syphilitic and tuberculous products: 1. The period of incubation of syphilis is longer, and the whole *clinical* curriculum assumes a more chronic character, than in tubercle. 2. The inoculated syphilitic knots are traversed throughout by fine vessels, while the inoculated tuberculous knots are entirely destitute of them. 3. The former never degenerate by caseous metamorphosis, which is the constant rule with tubercle. H. adds that the inoculation of LUPUS IN THE ANTERIOR CHAMBER produced absolutely no change. His experiments were made under the auspices of Arlt in Vienna.—*Archiv. f. Ophthalmologie*, Berlin, 1881, vol. xxvii, No. 3, p. 93.

Gumma of the ciliary body.—HOSCH, of Basle, Switzerland, narrates a case of this comparatively rare affection. The literature of this special theme has been collaborated in the *Archiv f. Augenh.*, ix, page 454, since which time there have been pertinent additions by Woinow, Bull, Loring, Eno, Alexander, Hirschberg, Arlt, and others. H.'s patient developed intra-ocular symptoms in the left eye seven months after the initial lesion, or four months after a successful specific treatment, as follows: Severe frontal headache; conjunctival injection; increase of tension (T+); great sensitiveness on motion; cornea stippled with small opacities; aqueous cloudy; iris discolored green; pupillary border adherent; vision = $\frac{3}{1000}$. Right eye normal. Patient was zealously treated with mercurial inunctions, calomel, atropine and morphia, baths and leeches for twelve days. Gumma appeared in upper and outer part of the sclero-corneal junction, of the size of a bean, which increased to that of a cherry. Pupil became enlarged downward, and was occluded by a grayish exudation. On the thirteenth day superficies of tumor changed from a spherical to a flat surface; its dark periphery became softer, more impressible to the probe, and less sensitive; conjunctiva less chemotic, though injected; the anterior chamber and cornea finally became clear. In twenty-six days the tumor was entirely flat, and in its location there was a large, triangular, pigmented spot, with its base at the corneal border. The pupil was traversed by a polychromatic membrane, adherent and triangular; V = $\frac{10}{200}$.

H. comments on the possible diagnosis of a fibroma of the sclera instead of a gummy neoplasm (a malignant tumor being out

of the question). The diagnosis of gumma is corroborated by earlier specific disease, and its prompt response to appropriate treatment, as well as by the early disappearance of the neoplasm under mercurial inunctions. In this connection, it is worthy of note that Schmidt-Rimpler had stated that a gumma of the corpus ciliare must necessarily ruin an eye. As to its location in the ciliary body, and not in the overlying sclera, its sudden development militates against the latter thesis, since this would be impossible among the interfibrillar spaces of so dense a structure as the sclera.—*Centralbl. f. prakt. Augenheilk.*, Leipzig, 1881, v, p. 365.

Retinitis syphilitica.—PAUL SCHUBERT, of Nuremberg, contributes clinical notes of a case of this rare disease. As evidence of its rarity he states that of the 20,000 diseases of the eye, which fell under Cohn's observation, the acknowledged ophthalmological statistician of Germany, only 231 (?) were instances of syphilitic involvement, while there was not a case of typical syphilitic retinitis. [In Schweigger's clinic in the spring of 1877, your reviewer saw a case of syphilitic retinitis accompanied by hemorrhages in the long axis of some of the upper venous twigs, especially of those circumambient to the macula lutea, in which there was also œdema of the retina, on the same side of the disc. The history of syphilis was unequivocal; a reduced vision was restored almost to $\frac{2}{3}$ with mercurial inunctions, and iodide of potash. E. S. P.]

S's patient first complained of a veil over the right eye. Eye painless; pupillary reaction equal in both eyes. With the ophthalmoscope a hemorrhagic retinitis was found. The principal vein of the fundus, running upward and inward, was lost near the optic nerve in a fresh, irregular hemorrhagic spot about the size of the disc itself. There were several branches from this vein, one of which ran obliquely over a white exudation. Another hemorrhagic spot lay near the macula, close to the principal artery, while in the upper and nasal quadrant the artery was crossed by several lateral branches of thrombosed veins. White exudations lay over and under the artery; also very dark, round blood-spots, with lighter centres. Viewed ophthalmoscopically in the indirect method with a $+\frac{1}{4}$ lens, or in the direct, NEITHER BLOOD-SPOTS, NOR EXUDATIONS LAY IN COMMUNICATION WITH THE ARTERY. The former sat, as it were, on the ends of the branches of the veins; while but a single spot of exudation had any connection with vessels. The macula itself was free, but the largest extravasation was in its vicinity. Of the retina the four inferior and outer veins showed white lines in their course, scarcely one third the diameter of the papilla, with a manifest diminution in their calibre. THE ARTERIES PRESENTED NOTHING ABNORMAL. The papilla and its periphery were normal; there was no evident retinal œdema; vitreous was clear, and field of vision intact; oc. dext. v = $\frac{10}{16.25}$; oc. sinist. v = $\frac{10}{9.75}$; punct. prox. = 9 cm. ($3\frac{1}{2}$ inches).

The patient gave exceedingly negative symptoms of syphilis. He had repeatedly been placed under such treatment, but had always doubted its authority; finally, upon consultation with a well-known oculist, he was disposed to believe its legitimacy. The only early genuine symptom was obstinate headache. Patient was married, had two healthy children; there had been no abortions nor premature births in his family. Exanthems and suspicious scars were absent, mucous membrane was sound, cervical and cubital glands were normal. Patient had a single indolent inguinal gland of the size of a walnut. Over the right parietal bone—the seat of the early headache—there was a defined spot of unusual sensitiveness upon palpation and percussion. Part was not elevated, but of softer consistency. Urine free from albumen.

The treatment was specific in character—inunctions, Zittman, Heurteloup, and atropine, abstinence from reading and writing, semi-darkened room, and coquilles. Absorption of the exudation began in fourteen days, and was complete in four weeks. By this time the hemorrhages were reduced in size and intensity, but the perivascular lines partially remained. $V = \frac{1.0}{9.75}$. S. adds that he regards these thromboses as due to infiltration of the perivascular lymph-spaces; as true hemorrhages, the result of vascular anæmia; and not a fatty degeneration or sclerosis of the walls of the vessels.—*Centralblatt f. prakt. Augenheilk.*, Leipzig, 1881, v, p. 329.

Syphilitic diseases of the lachrymal apparatus.—Dr. C. S. BULL in a clinical paper details a rare case of dacryo-adenitis, consecutive to syphilitic periostitis of the orbit. The orbital contents were removed to relieve excessive pain; the enlargement of the gland was found to be an increase of the connective-tissue elements, and was a true hypertrophy of the glandular structure. B. details two published cases of gummy infiltration of the caruncles in the practice of R. W. Taylor, who asserts their priority in the literature. Osteo-periostitis gummosa of the lachrymo-nasal canal has been mentioned by Panas, Galezowski, and Larebière, but B. has not observed it. Author advises rigorous mercurial inunctions of two drachms of ung. hydrarg. cinereum on the outer sides of chest or inner sides of anus, with small doses of the mild chloride every two hours, and to watch for the first symptoms of the drug. A neoplasm or gummy infiltration may block up the canal and simulate a stricture. Ophthalmic surgeons are too apt to slit up the canaliculi and incise a stricture in these cases of syphilitic involvement; the author believes that the patency of the passages may be restored by mercurial treatment.—*N. Y. Med. Fourn.*, etc., April 1, 1882.

[Arlt finds the seat of election of neoplasms and infiltrations, specific or non-specific, at the *isthmus*, between the saccus lachrymalis and the ductus ad nasum.—REP.]

RECENT LITERATURE.

- D'ANGELO, G. Gomma del periostio Nell' angolo superiore interno della cavità orbitaria. *Morgagni*, Napoli, 1881, xxiii, p. 255. (Index Medicus, 1881, No. 8, p. 377.)
- SCHROEDER, T. VON. Beitrag zur Kenntniss der Iritis syphilitica. *St. Petersburg*, 1881. (Index Medicus, 1881, No. 10, p. 482.)
- VELARDI, E. Studio sulla coroidite sifilitica. *Gior. internaz. d. Sc. Med.*, Napoli, 1881, n. s., iii, p. 379. (Index Medicus, 1881, No. 9, p. 424.)
- WIDDER, J. Ueber Iritis syphilitica mit Rücksicht auf ihr Verhalten zur allgemein luetischen Diathese. *Arch. f. Ophth.*, Berlin, 1881, xxvii, 2 Abth., p. 99.
- . Iritis syphilitique avec condylome de l'iris [3 cases]. *Journ. d' Ocul. et Chir.*, Paris, 1881, ix, p. 64.

Miscellany.

Death of Oscar Simon.—It is with very great regret that we are called upon to announce the death of Dr. Oscar Simon, Professor of Dermatology in the University of Breslau, which occurred on March 2d of this year, at the early age of 37. He had already taken a high rank among dermatologists both as a teacher and writer, his best-known work being “Die Localisation der Hautkrankheiten,” published in 1873.

He was present at the meeting of the International Medical Congress held at London in August of last year, and took an active part in its proceedings, reading a paper, before the Dermatological Section, entitled “Ueber Balanopostho-Mykosis.” In a personal acquaintance, extending over a period of thirteen years, we have always found him to be possessed of a large fund of knowledge, and withal very modest in the expression of his opinions. He could converse very fluently in several of the modern languages.

His death is especially to be regretted as he was one of the Committee appointed at the International Medical Congress to revise the present system of nomenclature and classification of skin diseases, and much valuable assistance was expected from him as the representative of the German views on the subject, which no doubt would have been placed before the Committee, by him, in a clear and impartial manner.

Dr. Duhring's book in Italian.—We take great pleasure in announcing the translation, into Italian, of the second edition of Dr. Duhring's work on “Diseases of the Skin.” Four fasciculi, including all the diseases down to impetigo contagiosa, have already been published. The translator of the book is Dr. A. Scambelluri, of Naples.

Reviews and Book Notices.

Traité théorique et pratique des Maladies de la Peau. Par J. B. Hillairet. *Rédigées et précédées de l'anatomie et de la physiologie de la peau,* Par E. Gaucher. Fascic. i, Paris, 1881, 8vo, pp. 227.

Since the days of Alibert, Cazenave, Bazin, and Hardy, the physicians of the Hôpital St. Louis, once the great centre of dermatological thought, have not been so active in promulgating doctrines as their predecessors, and no single name has stood out as a leader in this branch. Guibout's two volumes of clinical lessons, and Lailler's small book on parasitic eruptions, together with Fournier's contributions to syphilography, constitute about all which have appeared within the past ten years from this school, except small monographs.

The present fasciculus represents a portion of a proposed work of 800 pages, with figures in the text, and twenty chromolithographic plates, which will be issued in four fasciculi. It will be, therefore, one of the few complete recent French text-books on the subject of diseases of the skin, and will be the more acceptable as the volume already shows signs of a broad consideration of the subject, with due regard to the work in other lands: the French have too often exhibited comparatively little knowledge and appreciation of the work of others in the field of dermatology.

It is unfortunate that Dr. Hillairet has undertaken this work after he has retired from active service at St. Louis, being now only honorary physician to the hospital, Dr. Ollivier succeeding him; for this reason the subject is more apt to be considered from a speculative and theoretical standpoint than might otherwise be the case. Dr. Gaucher, an old interne of St. Louis, is associated as editor, and the first portion of the work, comprising 56 pages, upon the anatomy and physiology of the skin, are by him. These are very well given, and contain a number of wood-cuts, many of them being original. The illustrations are not as good as could be wished, and do not compare in delicacy with those of Sappey, some of whose are borrowed.

After a number of chapters on semeiology, pathology, etiology,

prognosis, and therapeutics, the author devotes 33 large pages to the subject of classification, giving a number of the schemes which have been proposed in full. It is somewhat startling to see the recent production of Auspitz translated into French (except, of course, the Latin names), and spread over ten pages. Our author also puts forward another classification of his own, covering five pages; this is on a mixed basis, pathological, etiological, and clinical, but unfortunately does not come nearer simplifying the subject than has been accomplished by previous authors. It is a pity that writers cannot agree more upon the nomenclature and classification of diseases of the skin, and it is hoped that much may be accomplished in this direction by the international committee on this subject appointed at the last Medical Congress in London. The thorough discussion of the subject, and the resulting simplifying of it, and agreement among writers and teachers, would do much to render the branch of dermatology intelligible to the medical profession at large.

The present work will certainly be a valuable addition to the literature of this branch, and marks an advancing grade of work by the French school of dermatology.

Eczema and its Management.—*A Practical Treatise Based on the Study of Two Thousand Five Hundred Cases of the Disease.* By L. Duncan Bulkley, A.M., M.D., etc. New York: G. P. Putnam's Sons, 1881. 8° pp. 344.

Dr. Bulkley says in his preface that the aim of his book is to present the general practitioner with as clear a guide as possible to the recognition and management of eczema. That this is an object well worthy the labor of the specialist in dermatology need hardly be said, when it is considered that not only is eczema the commonest of skin diseases, and likely to be met with by the general practitioner at least as often as all other skin diseases put together, but even after the abundant and fruitful labors of dermatologists during the last ten years, an appalling ignorance of the nature and treatment of eczema still exists among the mass of the profession.

Such bogies and ghosts as the *materies morbi*, and the horror of "striking in," must, it appears, still be encountered, and, indeed, are met with daily in consultations. But we think that Dr. Bulkley has given almost too much space to demonstrating the groundlessness of some of these prejudices. One of the best ways of eradicating error is, we are told, to advocate the truth and ignore gainsaying, and if we are constantly to evoke the spectres of dead and buried theory and nomenclature we run the risk of keeping in mind what should be forgotten.

It is otherwise with those questions of etiology into which Dr. Bulkley has gone so extensively. His views on the causation of eczema are here expressed at length, and form an important contribution to the solution of the disputed question as to how far local and to what extent general causes go in producing the ec-

zematous eruption. By setting aside, under the head of dermatitis many local eruptions formerly and still, sometimes, classed as eczematous, the question is somewhat simplified, and Dr. Bulkley brings to support his views as to the general causation the results attained by him in practice, and noted in his case-books.

How far the arguments and conclusions here stated will go toward convincing the strenuous and able opponents of Dr. Bulkley's views we cannot predict. But it is certain that constant and free discussion of these important points must clarify the polemic atmosphere, and possibly in time lead the combatants to some common agreement on this important subject of etiology.

While the sections on etiology and pathology in Dr. Bulkley's book are of more particular interest to the dermatologist, those on diagnosis and treatment are of the highest value to the general practitioner. We have only to compare this work with McCall Anderson's classic monograph on eczema, to see the advances which have been made in clearness and definiteness of our views of eczema in the past ten years, and to perceive also the improvements and additions to our armamentarium of remedies against the disease. In improving our means of treatment no one has been more active and successful than Dr. Bulkley, and this book, as the epitome and result of his labors and experience, must have the highest value to all who are obliged to treat eczematous affections.

The first fact to be remembered in the treatment of eczema is that there is not and never can be any specific remedy. This sounds like a truism, and yet, the question is daily asked of the dermatologist: "What is good for eczema?" Dr. Bulkley begins his answer to this question by a statement of the general principles of internal treatment called for by the various conditions of ill-health found in connection with eczema, and he then goes on to give his own opinions, based on his experience with regard to the uses of tonics, purgatives, etc. His remarks on the use and abuse of mineral waters are interesting and worthy of attentive consideration.

Under the head of the management of infantile eczema, advice is given as to the hygienic treatment of such cases which is of great importance; and Dr. Bulkley's remarks on the uses of ointments and of some of the stimulating applications, as far, are saturated with practical wisdom and should be assimilated by every practitioner who has the cure of his cases of infantile eczema at heart.

The treatment of eczema as it occurs in various localities is discussed at length, and for the most part satisfactorily, although in some places, as the section on eczema of the hands, arms, and genitalia, a little more fulness would be desirable, in view of the extremely stubborn character of these affections, and the frequently unsatisfactory results of treatment. However, this criticism is perhaps unjust, in view of the scantiness of our information on the subject. Let us hope that, in future editions, more and more may appear to help the puzzled practitioner in his struggle with these difficult cases.

The final chapter on diet and hygiene contains invaluable advice, which may be perused with advantage by every medical man, whatever his experience. For ourselves, nothing is commoner than to hear patients exclaim, on receiving ordinarily minute directions as to diet and hygiene, "Why, I never heard any thing of this kind before," the average medical man deeming it too often his only business to write a prescription.

We congratulate Dr. Bulkley and the dermatologists of this country on this substantial addition to our medical literature, and trust that its teachings may find a wide field in which they may bring forth much fruit.

A. V. H.

Syphilis et Mariage. Leçons Professées a l' Hôpital Saint-Louis. Par Alfred Fournier, Professeur a la Faculté de Médecine de Paris, Médecin de l' Hôpital Saint-Louis, Membre de l' Académie de Médecine. Paris: G. Masson, 1880, 8° pp. 288.

Syphilis and Marriage. Lectures Delivered at the St. Louis Hospital, Paris. By Alfred Fournier, Professeur a la Faculté de Médecine de Paris, Médecin de l' Hôpital St.-Louis, Membre de l' Académie de Médecine. Translated by P. Albert Morrow, M.D., Physician to the Skin and Venereal Department, New York Dispensary, etc. New York: D. Appleton & Co., 1881, 8° pp. 251.

Syphilis and Marriage. By Alfred Fournier, Professeur a la Faculté de Médecine de Paris, Médecin de l' Hôpital St. Louis, Membre de l' Académie de Médecine. Translated by Alfred Lingard, M.R.C.S. With prefatory remarks by Jonathan Hutchinson, F.R.C.S., Senior Surgeon to the London Hospital, etc. New York: Bermingham & Co., 1882, 8° pp. 98.

In this work, which is one of the most important in the department of syphilography that has been written in a number of years, Fournier proceeds to point out fully and clearly the dangers to be encountered by syphilitics marrying those unaffected. It possesses even a greater degree of importance at this time than it otherwise would, coming as it does when there has been so much discussion as to the comparative harmlessness of syphilis—a doctrine which, in our opinion, should be condemned without the least hesitation.

In the first chapter the duties of physicians toward syphilitics proposing to marry are well presented. The dangers to the future wife and offspring are clearly pointed out; and the physician is cautioned against being led from his duty by feelings other than those which should actuate him in giving advice on other subjects.

In the four chapters following, the question of transmission of the disease to the mother and the child is fully entered into.

Then follows a chapter on the personal dangers to which the husband may be exposed, that will unfit him for business and render him a burden to his family rather than a support. The author here treats the subject in both its moral and medical aspects, and although he may err rather on the side of forbidding

the marriage of one who has previously had syphilis, yet, taking into consideration all the facts, perhaps it is best that one should do so rather than expose many innocent persons to the danger of contracting the disease.

As to the conditions of admissibility of marriage of a syphilitic subject, five propositions are laid down for the guidance of the physician : 1. The absence of existing specific accidents. 2. The advanced age of the diathesis, and in this connection the author says that marriage should not be permitted until there has been a minimum period of three or four years of careful treatment. 3. A certain period of absolute immunity consecutive to the last specific manifestations, and the minimum time that should elapse without any manifestation of the disease should be from eighteen months to two years. 4. The non-menacing character of the diathesis, and this question has to be solved by the knowledge and experience of the physician ; when a person has had at any time syphilitic brain lesions, especially, although there have been no other symptoms of syphilis for a long time, he should be advised against marrying, so the author says. The fifth and last condition of admissibility to marriage is a sufficiently prolonged specific treatment, and it should consist in the administration of sufficiently large doses of mercury and iodide of potassium, the treatment lasting at least three years, and even after that the patient should be seen at least every two years, and be subjected to additional treatment.

The second portion of the work is devoted to a consideration of the duties of the physician toward the syphilitic after marriage, so as to remove as much as possible all accidents which are apt to result from such a union. In the final chapter, and by far the most important one in the book, syphilis is treated of both in regard to the dangers which may result to society from want of care, and also the means of prophylaxis are pointed out. In all cases where children are born with hereditary syphilis, whether the mother has syphilis or not, the author insists that they should be nursed by their mothers, in order to avoid all risks of transmission. In this connection it may be well to state that Fournier is a firm believer in the *law of Colles*. A number of cases illustrating and corroborating the different points enunciated in the text are given at the end.

The book is one that will repay careful perusal by all physicians, as all are constantly asked for advice on the subject treated of. The author has done very great service to the profession by the clear and able manner in which he has handled the subject. Both the American and English translations are well written, the latter being rather more freely rendered than the former. R. C.

Clinical Lectures on the Physiological Pathology and Treatment of Syphilis, together with a Fasciculus of Class-room Lessons Covering the Initiatory Period. By Fessenden N. Otis, M.D., Clinical Professor of Genito-Urinary Diseases in the College of Physicians and Surgeons, New York, etc. New York : G. P. Putnam's Sons, 1881, 8vo, pp. 116.

The book before us embraces a series of lectures, originally printed in the *Boston Medical and Surgical Journal*, and afterward collected in book form, and are well worthy of preservation and careful perusal.

The author is a firm believer in the dual origin of chancre and chancroid. He coincides with Biesiadecki, that the chancre is due to a local cell proliferation, and that the chancroid is the result of a process of destruction. He accounts for the short period of incubation in certain cases of syphilis, from the fact that in such instances the sore is found to be situated nearer the lymphatics, and in this way is more quickly absorbed than when the period of incubation is protracted. The amount of induration is also determined by the duration of incubation : when the latter is short we have but slight induration, *i. e.*, parchment induration ; and when there is a delay in the absorption of the virus the hardening is more extensive. The author holds to the view, that inoculation takes place at the point of contact of the virus, and that the poison is carried into the system by means of the lymphatics, and not, as claimed by some authorities, that the chancre is the result of the general infection, manifesting itself by a local reaction at the point of original contact. Instead of designating the period from the time of inoculation and the appearance of the eruption, the primary stage, he would call it the initiatory period of syphilis, which appears preferable. Contrary to the opinion of many writers, the author believes that syphilitic roseola is produced in a somewhat similar manner to a simple roseola, and that it is the result of an impression upon the sympathetic nervous system, a paresis of the vaso-motor nerves supplying the skin.

The work throughout is illustrated by cases, and the points raised by the writer are shown clinically. The description and recognition of the various lesions of syphilis are fully entered upon and the reasons for and against different theories are given, with conclusions drawn by the author. The chapters on treatment contain almost all that is known with reference to the subject. The subject of the excision of chancre is taken up, and the operation is advocated when the sore exists in loose tissue and can be readily removed, "not with the expectation of preventing constitutional infection, but, as far as possible, to remove a focus of dissemination of diseased elements, and to diminish the danger of conveying the disease to others."

At the end of the book is a series of class-room lessons covering the initiatory period of syphilis, and which was originally prepared by the author to aid the students attending his lectures.

This work differs from most epitomes and manuals, from the fact that it contains the result of a great deal of original study and experience, and shows evidences of careful preparation. It will prove of great value, especially to the student preparing for examination, and can be read with profit by the busy practitioner who wishes to refresh his memory in this all-important subject.

1. *The Student's Manual of Venereal Diseases : Being the University Lectures delivered at Charity Hospital, B. I., during the Winter Session of 1879-80.* By F. R. Sturgis, M.D., Clinical Lecturer on Venereal Diseases in the Medical Department of the University of the City of New York, etc. New York : G. P. Putnam's Sons, 1880, 12mo, pp. 196.

2. *The Student's Manual of Venereal Diseases : Being a Concise Description of those Affections and of their Treatment.* By Berkeley Hill, Professor of Clinical Surgery in University College, London ; Surgeon to the Lock Hospitals, and by Arthur Cooper, late House Surgeon to the Lock Hospitals. Second edition. London : Smith, Elder, & Co., 1878, 12mo, pp. 95.

3. *Cutaneous and Venereal Memoranda.* By Henry G. Piffard, A.M., M.D., Professor of Dermatology, University of the City of New York ; Surgeon to Charity Hospital, etc., and George Henry Fox, A.M., M.D., Surgeon to the New York Dispensary ; Lecturer on Diseases of the Skin, College of Physicians and Surgeons, New York, etc. Second edition, 16mo. New York : William Wood & Co., 1880.

1. In this book the author has collected together a series of lectures which he delivered during the session of 1879-80. In the chapter on the initial lesion of syphilis, the difference between chancre and chancroid are given in tabular form, so as to be of immediate service to those who may wish to refresh their memory on this point. The following rule is formulated, which is a good one to follow in the majority of instances, and more especially when there is any doubt about the character of the sore, viz.: *do not treat the initial lesion by the internal use of mercury, but await the development of secondary symptoms.* When speaking of syphilis of the palms, the author says that chronic palmar eczema is a rather uncommon disease ; we have, however, had a different experience, and often see eczema of that part of the body ; nor is the lesion on the palms surely a syphilide, when we get a clear history of syphilis, as eczema may frequently occur on the palms in connection with syphilis of other parts. There is no doubt that mercury in tonic doses will prove beneficial in most chronic squamous lesions of the hand, but it does not necessarily follow on that account that we are dealing with a syphilide. The chapter on treatment may be summed up in the words of the author : "Mercury is the mainstay in treatment, not only in the earlier but in the later stages as well." "Iodide of potassium is of little service in the earlier stages ; in the later stages, although of extreme value, it only assists in dispelling symptoms ; to produce radical effects it should be combined with mercury." "In giving both mercury and iodide of potassium watch your patient well to obviate toxic symptoms, and do not hesitate to use either remedy in sufficient amount to dispel the symptoms, no matter what the requisite dose may be." We think, in reference to the second of these rules, that mercury and iodide of potassium should be employed as soon

as the eruption makes its appearance, and their use continued until all symptoms of syphilis have disappeared, and have never found that any evil results followed, or that the patient did not get well as soon as under the use of mercury alone ; in fact, we believe the cure is hastened by the use of the mixed treatment.

A chapter is devoted to the subject of infantile syphilis ; and the remaining chapters, the last three of the book, are occupied with the discussion of gonorrhœa and its complications. Taken as a whole the book contains views that are accepted by the leading syphilographers of the day. The treatise is well written in a clear and forcible manner, and will be of very great service to those commencing practice, or even to those actively engaged in their profession. We are sorry to see that there is no index, as it renders it difficult to find the different subjects that are spoken of.

2. This treatise is simply a summary of the author's larger work on "Syphilis and Local Contagious Disorders," and is only intended as a sort of manual for students. It is divided into five parts ; in the first portion a historical sketch is given of venereal affections; the second treats of syphilis ; in the third the soft sore, with its complications, is discussed ; gonorrhœa constitutes the fourth part ; and the last is occupied with the description of the various complications that may arise in connection with venereal disease. At the end of the book is a well-selected formulary. In speaking of the local or soft sore (chancroid), we think that the authors are apt to cause confusion in designating it by the name of chancre. The different subjects are treated of in as clear and concise a manner as the limited space will permit, and the book will be of service to those who simply wish to refresh their memory on so important a subject as the one treated of.

3. This little book, which has passed to a second edition, treats of skin and venereal diseases in a concise and simple manner. In the main, only facts are given which are accepted by the majority of dermatologists. The various diseases are described briefly, and in such a way as to be available, as well to the busy practitioner, who has but a faint knowledge of skin diseases, as to the student of medicine.

The chapters on anatomy, physiology, and pathology of the skin are good as far as they go, and this may be said of the chapters treating of the various diseases. In the treatment of eczema exception may be taken to the applications of poultices, as they only tend to weaken the skin, confine the secretions, and promote further unhealthy action ; in our hands a suitable ointment thoroughly applied has answered the desired purpose ; nor is it necessary to have the hair cut short in eczema of the scalp, except in very rare instances.

There is a very good chapter on the various complications of gonorrhœa, and Fournier's tables are given, from which the differential diagnosis of gonorrhœal rheumatism and the simple form can be made, as well as gonorrhœal ophthalmia from gonorrhœal conjunctivitis. In the treatment of syphilis great stress

is laid upon the employment of mercury in all its stages and manifestations, a point which cannot be emphasized too much.

R. C.

The Pathological Changes caused by Syphilis at the Fundus of the Eye. By Ole B. Bull. Christiania: H. Aschehoug, 1881, 8° pp. 103.

Ten years ago the author began to examine the fundus of the eye in persons affected with syphilis, and wrote treatises on the subject in 1871 and 1875. The present work is based upon the ophthalmological examination of eight hundred patients suffering from constitutional syphilis.

The author at first treats of *hyperæmia nervi optici*, the most common form of syphilitic ophthalmia, and says that it is often doubtful whether the condition is a pathological one or not. In some cases the hyperæmia is undoubtedly present, and may go as far as to the formation of a stasis of the papilla. In three cases the author has seen ecchymosis around the papilla, but believes that it is of very rare occurrence. As a rule the hyperæmia entirely disappears, but the experienced observer can generally point out a slight opacity of those parts of the retina which are contiguous to the optic nerve. Its presence does not necessarily imply any impairment of the visual strength, but the functional endurance is often diminished. It must be classed among the secondary symptoms of syphilis. Bull has never found it later than two years after the infection. It may appear very early, and may then have diagnostic value. From a calculation based on four hundred of his patients, the author estimates its frequency as eighteen per cent., and believes it is related to headache and other nervous symptoms. The treatment ought never to be very energetic. The hyperæmia disappears together with the other symptoms under the common anti-syphilitic treatment.

The author has seen but comparatively few cases of *neuritis optica* and *atrophia nervi optici*, probably because these affections appear at a late period, when the other symptoms of syphilis have commonly disappeared. Other authors have often found the same forms. Bull reports two cases in which hyperæmia and œdema of the optic nerve were combined with signs of more profound trophic disturbances, such as extravasation of blood, plastic inflammatory products, or signs of atrophy. A pure atrophy in consequence of syphilis seems to be rare.

The author is inclined to think that in the large majority of cases, affections of the retina and choroid are due to the same pathological process, which originates in the retina, and, after a shorter or longer interval, invades the choroid. The most appropriate name is, therefore, *retino-choroiditis*. The impairment of the visual strength, which is one of the serious symptoms of the affection, is preceded by certain functional disturbances, of which photophobia is the most constant. Often it is allied to scotomas, or deficiency of vision limited to one half of the optic field. Sev-

eral other symptoms are intimately related to the scotomas. This is the case with the great diminution and changeable condition of the visual strength frequently found in the beginning of the disease. The visual strength may change considerably from one day to the other, in consequence of the invasion of the macula lutea by a scotoma which before occupied a peripheral position. Another symptom related to the scotomas is the metamorphopsia, especially micropsia, much more rarely megalopsia. One of the most constant symptoms is impairment of the visual sense. It is a much-mooted point if the color-sense undergoes any change. Bull, from his own investigations, comes to the conclusion that the disturbances in the color-sense are due to the impaired visual power of the percipient elements of the retina. Myodesopia may be found in an early stage of the disease, but appears as a rule late, and may become a constant symptom. Besides, almost all patients complain of lacking functional endurance, while pain and photophobia are inconstant symptoms. It appears from the descriptions of the subjective symptoms, that there are none pathognomonic of syphilitic retino-choroiditis. Nor are the objective symptoms particularly characteristic. They are those commonly found in inflammation of the outer layers of the retina. In most cases the diagnosis must, therefore, be based on the other symptoms of constitutional syphilis. The author next describes the condition revealed by the ophthalmoscope in the different stages of the disease. He bases his conclusion that the disease, in most cases, starts from the retina, on the facts that the scotomas spread fan-like from the optic nerves, in some cases resulting in deficiencies which only reach the median line, as in hemianopsia; that in fresh cases no changes are found in the choroid; that the clear spots, which originally are only due to atrophy of the pigmented layer belonging to the retina, are found in greatest number in the places formerly occupied by the scotomas; and, finally, that the atrophy is quite often found along the vessels of the retina. But, on the other hand, the whole affection not uncommonly begins as an iritis, from which we may infer that in several cases the choroid is the starting point.

The disease known as *retinitis pigmentosa* and its relation to syphilis are discussed on pages 83 and 84. The rest of the book contains a description of the changes taking place in the exudations, the appearance of œdema of the retina, detachment of the retina and glaucoma as consequences of syphilis, and the frequency of retino-choroiditis, which is estimated to be found in eight or ten per cent. of all persons tainted with syphilis. The retino-choroiditis is likewise, as a rule, a secondary symptom. It takes ordinarily a subacute course, and the prognosis in general is good. Although it not often leads to the diagnosis of syphilis, there are, nevertheless, characteristic cases. A disseminate choroiditis, with a distinct gray opacity of the retina around the optic nerve, is a form of disease almost characteristic of syphilis.

The last four pages contain references to the the literature of the subject.—From the *Hosp.-Tidend.*, Copenhagen, Oct. 12, 1881, vol. viii, No. 41, by H. J. Garrigues.

Lectures on the Parasitic Diseases of the Skin—Vegetoid and Animal. By James Startin, Surgeon and Joint Lecturer to St. John's Hospital for Diseases of the Skin, Leicester Square, London. With illustrations. London: H. K. Lewis, 1881, 8° pp. 88.

It is difficult to conceive the object of the author in placing this volume before the public; no new ideas are set forth in it, while many erroneous ones are given, and there are already other and far better works on the subject.

As an instance in point we quote the following: In the chapter on favus we find this statement: "The hair should be closely cut and epilated, but *this is not a matter of so much importance as in epiphyton capitis*"; the latter portion of the sentence is italicized because, in the opinion of most dermatologists, it is of far greater importance to epilate in favus than in tinea tonsurans, since, if it is not done the cure will be retarded, if not altogether prevented, and permanent baldness result. Another error which the author makes is to state that tinea versicolor is very contagious, whereas in reality it is the least contagious of the vegetable parasitic diseases. It has also been pretty conclusively shown of late that alopecia areata, here reckoned as parasitic, with the obsolete name tinea decalvans, is not caused by the presence of a parasite. Certainly we have always failed to discover any parasite in it. The author probably does not intend to class acne among parasitic diseases of the skin, but to those not familiar with the subject it would appear to be from his statements in connection with the acarus folliculorum. We think it a mistake to use the term prurigo—the name of a disease—for pruritus, which is only a symptom, as occurs in the book before us in connection with pediculi.

The book shows evidence of having been carelessly read, such mistakes as the following being frequent, "cloasma," "inoculation," "canaliculi" for "cuniculi." The author announces that he has in preparation a work on the skin; it is sincerely hoped that it will not contain the proportionate amount of errors which are found in the present one; such books were better unwritten.

R. C.

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Original Communications

ON CHRONIC SKIN DISEASES TREATED BY THE WATERS OF AIX-LA-CHAPELLE.

BY DR. SCHUMACHER, JR.,

RESIDENT PHYSICIAN, AIX-LA-CHAPELLE.

THE hot springs at Aix-la-Chapelle were already in use for bathing purposes in the time of the Romans. It was most probably the celebrated Sixth Legion, which had won the honorable title of "Legio victria" by its glorious victories in Spain, that first erected splendid bathing-houses at our springs, known to the oldest authorities as "Aquæ," or "healing waters." The remains of these baths, built between 69 and 120 A.D., were dug out in 1878. Many ornaments and articles of feminine toilet were found in the canals and bath-rooms, and have, together with other curiosities, been placed in the museum of this city. The newly discovered foundations are accessible to all who are interested in these relics of a by-gone age.¹

From Germany the Sixth Legion went to Britain, and most probably erected the large building for warm baths at Bath—at the Aquæ Solis,—the foundations of which were laid bare in the last century.

The Roman buildings at Aix-la-Chapelle were destroyed by the invading barbarians, whose countless hordes of warriors carried death and desolation to the very walls of the

¹"Ruins of the Roman Baths at Aix-la-Chapelle," Dr. Lersch, 1878.

Eternal City. Six hundred years passed by before the first great German emperor, Charlemagne, rebuilt the baths on the same site. It is said that he discovered the hot springs whilst hunting in the woods, which at that time covered the neighborhood. The emperor was in the habit of bathing with his whole court in the long "piscines" or common baths, according to a custom which continued to exist up to the end of the Middle Ages.

In the Latin writings of the Middle Ages, Aix-la-Chapelle is called by the significant name of "Aquisgranum," from which the present German name of "Aachen" is derived.

About 1756 the celebrated English doctor, C. Lucas, in his well-known work, entitled "An Essay on Waters," gave the highest praise to the improved contrivances for private baths at Aix-la-Chapelle; and these arrangements have not since been changed, except for further improvement.

In 1655, shortly after the Thirty Years' War, the renowned Dr. Franz Blondel instituted the practice of drinking the waters as a means of great importance in curing certain diseases. He was much interested in Aix-la-Chapelle, and his discovery added greatly to the benefits of treatment at these baths; but in his time he must have met with much opposition from some of the medical men of his day, for in 1688, in his interesting work on "Thermal Aquisgranenses," we find him devoting two whole chapters to the refutation of the unfair charges brought against his treatment, by narrow-minded though scientific adversaries.

The sulphur-springs at Aix-la-Chapelle have continued up to the present time well-known and much used for their healing powers. These healing properties have been proved to exist by the experience of centuries, by the chemical composition of the water, and by their physiological effect on the system.

The water of our warm springs is very digestible. Its principal chemical ingredients are sulphur, chloride of sodium, and carbonate of soda. The waters of the Kaiserquelle, at Aix-la-Chapelle, contain in every 10,000 grammes or about 10 litres (3 gallons):

Chloride of sodium . . .	26.1 grammes (nearly 7 drachms).
Carbonate of soda . . .	6.4 " (1½ drachms).
Sulphurate of sodium . . .	0.1 " (1½ grains).
In 10 litres (nearly 3 gallons) of gaseous elements	
Sulphurated hydrogen . . .	0.3 grammes (4½ grains).

At our springs, therefore, we have the advantage of the united effects of sulphur with chloride of sodium and carbonate of soda, which is of great importance in the external and internal use of the waters. The heat of our springs rises as high as 131° Fahrenheit.

To a certain extent Aix-la-Chapelle is in complete contrast with England and North America, which, according to the geological condition of their soil, possess only cold sulphur-water springs, none of which can be called alkaline, as they are all impregnated with indigestible ingredients of sulphate of lime or magnesia. In England there are few warm springs of high temperature, with the exception of the one at Bath, which is far behind the Aix-la-Chapelle springs in warmth. In North America, in the States of New York and Virginia, which are so rich in sulphur-springs, no springs, as far as we know, have a higher temperature than 60° to 70° Fahrenheit; and those in Utah and Southern California, which resemble our springs as regards temperature, are not yet properly adapted for medical use.

Chronic skin diseases form one of the chief classes of illness at Aix-la-Chapelle.

A medical gentleman, who is thoroughly acquainted with our springs, Dr. Macpherson,¹ writes: "Aix-la-Chapelle has long been known to possess the chief sulphur baths of Germany, and is well known to English people. Every result that sulphur baths not at a great elevation, like several in the Pyrenees, can produce, is to be met with here; but rheumatism and cutaneous affections are the complaints most successfully treated. The baths are of established reputation, and possess a staff of experienced medical gentlemen, whose practice in a large city like Aix-la-Chapelle, is not limited too much to one set of diseases, as is the case at most other baths."

¹ Dr. Macpherson's "Baths and Wells of Europe," 1869, p. 141.

It is almost impossible to realize all that has been gained for medical science by the local treatment of skin diseases. But the fact remains that for thousands of years the best doctors have pointed to bathing treatment, and more especially to sulphur baths, as the very best means of effecting a thorough cure in cases of local skin disease. "The steady growth of so many different mineral-water bathing-places, and the eloquent evidence of thousands of grateful patients cured at these baths, are the best proofs of their unfailing efficacy."¹

Chronic skin diseases are to be treated at the mineral springs more or less as constitutional affections.

The skin, like every other organ, cannot escape the influence of disease for any considerable time, when the principal organs are in an unhealthy state and the system is upset. The connection between these diseases still remains to be explained; experience can only prove it to exist.²

Scrofula is often combined with "*lichen scrofulosorum*" and "*lupus*"; in individuals whose health has been undermined by cachexia, we find *acne cachecticorum*; chlorotic patients are subject to changes in the color of the skin, pallor, *seborrhœa*, and *effluvium capillitii*. Rheumatism and gout form the foundation of *lichen agrius* (Willan); climatic or endemic influences, often of a malarial nature, which act by deteriorating the system generally, give rise to *frambœsia* in the West Indies, to *sibbens* in Scotland, and to *elephantiasis*.³ Diseases of several organs are also liable to produce symptoms of many skin diseases. Pigmentation, icterus, urticaria, pruritus cutaneus, eczema—often of great obstinacy,—are the consequences of liver affections; and as a result of diseases of the uterus and ovaries we see the procreation of *chloasma*, *acne rosacea*, *seborrhœa*, and urticaria.⁴ Besides these morbid changes of internal organs of the body, skin diseases are often brought on by age, irregular living, and bad or unsuitable food.⁵

¹ "Physiology of the Skin," by Dr. Röhrig, 1876.

² "Lehrbuch der Hautkrankheiten," by Dr. Neumann, 1880, p. 62-66.

³ "Skin Diseases," by Dr. Tilbury Fox, 1873, p. 51.

⁴ "Lehrbuch der Hautkrankheiten," by Dr. Neumann.

⁵ "Lehrbuch der Hautkrankheiten," by Hebra.

Finally, observation proves that diseases of the nervous system, more especially of the vaso-motor nerves, are the agents, in several cases, leading to skin disease. We find this, according to the best authorities, in cases of herpes and pemphigus. In the genesis and prolongation of eczema, neurasthenia and functional nervous symptoms were constantly observed, and often played a very important part.¹ These observations show beyond doubt that many skin diseases are of constitutional origin. A further indisputable proof of the fact is that several skin diseases are hereditary; the disease passing from the parents to one or to all their children, or to their grandchildren. The frequent reappearance of these diseases in a patient apparently thoroughly cured, is a still stronger proof of the correctness of this theory. Success is, therefore, chiefly to be sought in a combination of local and constitutional treatment at the baths; the latter being acknowledged to be particularly important.

In Aix-la-Chapelle, as regards the usual cases of illness, local treatment—which has been proved by experience and scientific research to be very important—is naturally not neglected; but on the other hand it is well known, that many patients in whom local measures have failed to effect a cure after many years have finally been thoroughly cured by using the hot baths, and submitting to the constitutional treatment, as practised in Aix-la-Chapelle.

In the treatment of these diseases it is of the utmost importance that the patient should reside in the neighborhood of the baths during at least from four to six weeks, or, if possible, till every sign of disease has disappeared. Patients are required to remain a considerable time in the water,—generally about an hour; if necessary, two baths a day may be taken. The temperature of these baths must not be too great, as otherwise patients are too easily fatigued; the age and constitution of individual patients must be taken into consideration. Baths of long duration are easily borne even by very young patients. In most cases ordinary baths of sulphur water produce the required results in skin diseases,

¹“Eczema and its Management,” by Dr. L. Duncan Bulkley, 1882, p. 21.

but in some cases, where it is found necessary to strengthen and stimulate the action of the skin, warm sulphur-water douches are used. Hot sulphur steam-baths are of very great importance to those patients in whom the skin is greatly thickened, with a tendency to become scaly.

As the Springs at Aix-la-Chapelle, and the neighboring town of Burtscheid, vary in strength and warmth, we are easily enabled to give patients the change of treatment so often necessary in chronic cases.

It is necessary to explain to patients who have suffered from skin disease for years before coming to us, that after being cured here the eruption may appear again; it is, therefore, prudent to repeat the treatment. This becomes necessary partly because the majority of patients, on their return home, resume their old manner of living, probably vitiating the blood and thus bringing about a return of the old illness. The results of our treatment are then very apparent in the mildness of the returning disease, over which it is possible to exercise full control. In many cases a full and final cure is possible, and to this end both doctor and patient must persevere.

Our treatment is very considerably facilitated by the handsome bath-houses, where every thing is tastefully arranged and most thoroughly adapted to the comfort and requirements of every patient. The bathing-houses, eight in number, contain on the ground floor excellent arrangements for ordinary baths, douches—the best in Europe, —steam-baths, and sweating-rooms, and all have a spring where patients can drink the waters during bad weather. The immense quantity of water and the number of baths (about one hundred and ten) enable several hundred patients to bathe every day. Separate private baths for ladies are set apart in some bathing-houses.

In Aix-la-Chapelle the treatment is carried on during the whole year; the bath-houses are always open and in use, for the mildness of our continental winters has gradually created a winter season; numbers of English, Swedes, and Russians are constantly visiting the town.

Eleven years' observations¹ at our meteorological station give an average temperature for

November of	+5.3° C. (14.° F.)	with snow on 2 days.
December “	−0.9° C. (3.° F.)	“ “ “ 7 “
January “	+1.9° C. (5.° F.)	“ “ “ 6 “
February “	+4.1° C. (11.° F.)	“ “ “ 7 “
March “	+5.6° C. (15.° F.)	“ “ “ 9 “
April “	+9.6° C. (26.° F.)	“ “ “ 3 “

This winter we have had neither snow nor frost, and consequently the number of winter patients has been very high.

Many years of medical experience prove the advisability of a winter treatment for skin diseases.²

If we examine more carefully the special cases in the group of skin diseases most frequently met with at Aix-la-Chapelle, we find that a good field for the operations of our bathing treatment is offered by chronic eczema. To this class belong all those cases which seem to revive in spring and autumn, and also those which are not influenced by the seasons. Those diseases brought on by continued local ailment, or by the unhealthiness of any particular organ, belong also to this class; finally, also, those cases from which we can draw no conclusion as to their etiology.

We learn here, that several forms of the catarrhal affection of the skin are benefited by the waters. Besides eczema papulosum, e. pustulosum, and e. rubrum (which is liable to produce ulcers), our attention is particularly called to the final development of the different forms of eczema, to eczema squamosum. The itching attendant on these diseases is most satisfactorily lessened here. The skin lesions gradually become less in extent, the hard infiltrations disappear, and a normal condition of the epidermis is gradually arrived at. Many of the worst cases of eczema, which had spread over the upper and lower extremities of the patient, and would not admit of any local application, have

¹ “The Climatic Winter Watering-places of Central Europe and Italy,” by Dr. H. Peters, 1881, p. 31.

² “Winter Treatment at Aix-la-Chapelle,” by Dr. Reumont, 1867.

finally yielded to the continual use of baths, and have been thoroughly cured.

We can also recommend the sulphur-water baths for pustular affections of the skin. This group is represented principally by acne, the consequence of limited inflammation of the follicles of the skin (*acne disseminata*). The best results are achieved in our treatment of *acne scrofulosorum* and *acne cachecticorum*; but sometimes the patient must reside near the baths for at least several months. The thick, scaly infiltrations, often so painful, gradually disappear, generally before suppuration sets in; at the same time the system is strengthened and the patient fully restored to health.

The treatment of furunculosis, frequently observed here, is less remarkable for its rapid and painless cure, than for the way in which the whole system is acted upon, and a return of the disease rendered very doubtful.

Psoriasis (*lepra Willani*) is met with here in all its stages. Local treatment has of late years worked wonders in curing psoriasis. But the more we know of this extremely obstinate, wide-spreading complaint, the more we are convinced of the good done by the baths, either with or without the aid of other medicines; and here more especially our attention is called to the connection between local and general treatment at the warm springs.

We do not deny that internal medication is of importance after treatment at Aix-la-Chapelle. When the treatment here has removed all the diseased appearances on the skin, it is sometimes found advisable to resort to constitutional measures, giving such preparations as copper and arsenic at stated intervals for a year. By this means the tendency to a return of the psoriasis is greatly lessened.

The perfect system of our bath routine is exactly suited to the thorough treatment of psoriasis. In a proportionately short time the scaliness and the itchiness of the skin, so frequently met with in these cases, decrease, and are finally altogether driven out by the use of our baths.

Our douches and steam-baths (gases and steam of our waters) are particularly excellent in obstinate, torpid cases.

They act by strongly exciting the functions of the skin, through their energetic action on the nerves, on the blood- and lymphatic vessels, and on the glands of the skin, by pushing out diseased and renewing healthy matter.

In these cases it is important, as far as the prognosis is concerned, to know the age of the patient and the length of time he has been suffering from the disease. Patients from ten to twenty years of age are the best subjects for perfect cures, if they are free from any taint of hereditary disease. But a repetition of the treatment is generally necessary. If the disease has been going on for years, and although apparently cured by local treatment it has invariably broken out afresh, we must insist on the patient looking forward to courses of treatment for from two to three years.

We have had several young ladies here who have been thoroughly and lastingly cured by our treatment in from five to eight weeks. In most cases, however, a repetition of the treatment was rendered necessary in a year's time by the reappearance, in a milder form, of the disease. In a few instances the eruption reappeared after an interval of two years, but a repetition of the course of treatment at Aix-la-Chapelle gave a final decided result. From our experience we can recommend the bathing treatment here, not only for the rapidity with which it cures all outward signs of the disease, but also for strengthening the system and eradicating the tendency to psoriasis.

In the group of papular inflammations of the skin, in Aix-la-Chapelle, we find that prurigo is favorably influenced by our waters. We have on several occasions succeeded in producing good results in cases of this kind which, though mild, were well developed. The papular infiltrations disappeared and the itching was removed; excoriations of the skin and the swelling of the glands were gradually healed. Usually in these cases of prurigo there were signs of general debility, similar to those in furunculosis and acne cachecticorum, and both were favorably influenced by our treatment. In America and England this disease is reported as occurring very rarely; Dr. Tilbury Fox first described it. Still at the London International Medical

Congress last year, several well-developed cases were seen by us, a fact casting serious doubt on the rarity of the disease.

Cases of pruritus cutaneus are more frequently met with here than prurigo. Signs of the itching were to be found in some cases without any apparent external cause, either all over the skin or principally about the mouth, eyes, genital organs, and anus. In many cases of pruritus some internal organs showed signs of disease, and menstruation was irregular; in the latter cases the vainly expected menstruation was preceded by from eight to ten days of unbearable itching. Others suffered most probably from irregularities of the stomach and from the so-called hemorrhoids. One case was combined with chronic nicotine (tobacco) intoxication. In many cases different members of the same family were affected by pruritus.

In a few particular cases it was difficult to decide whether the slightly developed dry catarrh of the skin was the original cause or only a consequence of pruritus. Both disappeared under our treatment, but generally showed a tendency to return. The success of our treatment was, on the whole, satisfactory, especially when the internal disturbances were favorably influenced by our waters.

To this class belong all those ailments of the abdomen which benefit by thermal treatment.

That form of pruritus which shows itself in the later years of life in connection with senile decay of the skin (pruritus senilis), has sometimes benefited by our treatment. The most obstinate cases were those of pruritus in middle-aged patients whose constitution and skin seemed to be in a normal condition. With these often only a transitory result was arrived at. Experienced Aix-la-Chapelle physicians recommend the baths for lupus when it appears after scrofula. We have not personally met with such cases.

During the last few years we had two cases of true leprosy from Brazil. These cases were not of a tubercular character, but appeared with anæsthesia and discoloration of the skin, accompanied by a general feeling of illness. These cases derived such great benefit from the baths, that we consider ourselves justified in calling attention to them.

We conclude with an important class of skin diseases, which, although they do not primarily originate in the skin, appear on its surface in a secondary manner, and therefore are justly classed in this group. We refer to the ulcerated sores on and in the skin of the shins. In this large city, with its population of about 90,000 souls, we have every opportunity of studying these cases, and are quite willing to acknowledge the beneficial results of local treatment. But our experience of various most extensive and serious cases, during several years, has taught us, that in curing these sores, our bathing treatment is most valuable and important. We use the baths either with or without local treatment, with the view of not only healing the ulcerated sores, but also of retaining the successful results. We ascribe the importance of our thermal treatment to its action upon the original causes of ulcerated shins, because it changes and stimulates the disturbed circulation of the blood and improves the eczema, the scrofula, and the gout, which often co-exist in these cases.

All this suffering is by no means the sad privilege of the poorer classes. Most of our patients come from the upper classes of society. Frequently the ulcerated sores had already been healed by local treatment, but the inevitable return of the malady brings the patients naturally to Aix-la-Chapelle. In most cases the disease appears in middle-aged and old people. In slight cases no ulcers were to be found; but there appeared œdematous swellings of the skin, especially round the joints of the foot, which, by their pressure on the nerves, brought on paræsthetic sensations, shivering and cramps. In more developed cases inflammation in and round the veins was visible, followed by a thickening and discoloration of the skin, by eczema, and by pruritus. In fully developed cases the ulcerated sores showed themselves generally in two forms, seldom found united in the same patient.

In the first case the characteristic *ulcus cruris* was visible, at times with a pair of ulcers originating probably from a blow or from scratching. In the second case we found that along the skin of the shins, seemingly without any direct

cause, several irregular, generally small superficial sores had been formed, the diseased parts having loose, indistinct edges, often connected by a thin ridge of skin. These little ulcers bled very easily, and were rendered excessively painful by the nerves being laid bare by the sores, thus becoming a great hindrance to a patient in the daily performance of professional duties. In the first case the veins were generally enlarged and the extremities of the patient more or less emaciated. The last cases were not generally connected with any serious enlargement of the veins, but, on the other hand, the panniculus adiposus was strongly developed.

In the treatment of ulcerated shins and the different stages of the disease, the use of our baths, and especially of our warm douches, was found to be of very marked benefit.

In the above chapter we have endeavored to lay before the professional reader, in a cursory manner, an important class of diseases which may be successfully treated at Aix-la-Chapelle. The opinions and views we have advanced are throughout founded on our own personal experience, and we shall be satisfied that our aim has been attained, if the work meets with the willing interest to which our common wants entitle it.

ON PRURIGO, OR ECZEMATOUS PRURIGO.*

BY MR. W. MORRANT BAKER, LONDON, ENG.

IN the present brief communication I am desirous of drawing attention to a disease of which I have seen many examples during the last few years, and which, as I gather also from conversation with others, is not very rare in this country.

The leading feature of the disease, as commonly seen, is eczema, wide-spread and most intractable. The face and upper part of the neck, the arms and forearms, the thighs and legs, usually their extensor surfaces, are the parts most affected; but the trunk does not escape, and the disease may be as bad here, in patches, as elsewhere.

The eczematous patches, as usually seen, are partly scabbed, partly raw, here and there pustular, especially at the margins, while their outlines are suggestive of the scratching to which they have been subjected. But, on looking more closely, it is obvious that the term eczema does not express all that is present. Between and around the patches of eczema the skin is more or less thickened and dry, and on passing the finger over it, it feels rough and sand-paper-like, or even prickly, but often it seems as if the rough papules were seated on a glazed and almost scar-like base. In some parts the skin is merely dry and a little scaly, as if xerodermatous; and, again, a large tract of skin may be healthy, especially in the flexor aspects of the limbs.

The intense itching to which the patient is subject is represented by lines of scratched skin more or less marked, and

* Transactions International Medical Congress, London, 1881.

the pruriginous aspect is heightened by the tiny blood-topped hard pimples which are scattered in the neighborhood more or less profusely. Scattered pustules are also not rare, and the disease may bear close resemblance to scabies.

The lymphatic glands corresponding with the diseased districts are enlarged; the femoral the most notably. Pigmentation has not been a very marked feature in more than a small proportion of the cases which I have seen.

The general health is not very much affected, but sometimes the patients are anæmic.

In all the cases which I have seen, the disease is said to have begun in early infancy, and to have continued with merely remissions since that time. And in no case have I seen any other than temporary benefit as the result of treatment.

I have described thus briefly the characters of the disease for identification, but have avoided minute details, as my immediate object in bringing these cases before the Congress is that I may obtain an expression of opinion as to whether these cases are identical with those to which the late Professor Hebra more particularly applied the term *prurigo*.

I had been long familiar with the disease before I had begun to associate it in my own mind with Prof. Hebra's *prurigo*, and I am indebted to Dr. Buchanan Baxter, with whom I saw one of the cases in consultation at the Evelina Hospital, for the information that such cases had been called *prurigo* by dermatologists from the Continent, who had seen them in England. I have since discovered that others had come to a similar conclusion, and I may refer especially to Dr. Liveing, who, in the last edition of his work on the diseases of the skin, calls attention to the existence of cases of Hebra's *prurigo* in England, and to the causes which have led to its being frequently overlooked.

Dr. Liveing remarks: "The malady has hardly received the attention and recognition that it merits from English observers. Some modern writers deny altogether its existence in England. There can be little doubt that by many

the disease is not recognized from Hebra's description, and indeed this is scarcely to be wondered at. . . . There are several reasons why we often fail to find what I may call the typical eruption of prurigo. (1) The papules he describes (they have not at all the appearance of vesicles) exist as such only for a very short time, and they are quickly injured by the scratching of the patient; this fact, together with the constant presence of excoriations, eczema, and other changes in the skin, makes it difficult to find them. (2) The large papules, though pale, are not always of the same color as the surrounding skin, but often of a distinctly redder tint. (3) Hebra has, for the purpose of diagnosis laid too much stress on the elementary form of the eruption, and not enough, by comparison, on the history of the disease, which is, after all, a more important diagnostic feature."¹

At the same time, I may quote the following remarks as a justification for my endeavor to elicit opinions on this subject: Mr. Hutchinson, whose opinion on any matter connected with diseases of the skin is entitled, as all will acknowledge, to the profoundest attention, has devoted a chapter, in his "*Lectures on Clinical Surgery*," to the question, "Is Hebra's prurigo met with in English practice?" and, as all here are aware, he replies in the negative.

Dr. Duhring, in the last edition of his work on "*Diseases of the Skin*"² remarks: "Prurigo, as described by German writers, is an affection so rare in England and the United States as scarcely to exist in those countries."

Dr. Tilbury Fox, in the third edition of his work on "*Diseases of the Skin*" (1873), says: "I have been on the look-out for a case of the most marked form of disease, such as Hebra describes, for years past, and have only met with one case in England."

The question therefore arises: "Is the disease here referred to, and of which I exhibited cases on Saturday last to the members of the Congress, the prurigo of Professor Hebra?"

¹ "*A Hand-book on Diseases of the Skin*," by Robert Liveing, M.D., 1880, p. 141.

² "*Diseases of the Skin*," by Louis A. Duhring, M.D., 1881, p. 247, *note*.

If it be so, then we must give up the very generally accepted belief that prurigo is rare in this country; although, to judge from Professor Hebra's description of typical cases, the disease would appear to exist amongst us in a far milder form, in most cases, than on the Continent. If, on the other hand, the disease be distinct from Hebra's prurigo, we have before us, I venture to think, a variety of prurigo to which the terms eczematous prurigo and pruriginous eczema seem about equally applicable, and which deserves a recognition which has not yet been accorded to it. The symptoms appear to me to be quite distinctive from those of any other disease. So far as I have been able to observe, it is quite a different malady from infantile prurigo, or lichen urticatus, with which one is tempted to find an alliance.

I believe it to be also distinct from the relapsing prurigo of Mr. Hutchinson; but regarding this I will not venture to speak with confidence, as I have not had an opportunity of seeing cases to which I am warranted in saying that Mr. Hutchinson would apply the term.

Instead of occupying the time of the section by the narration of cases, I have exhibited living examples of the disease to which I venture to call attention.

In the discussion which followed, Prof. Kaposi, of Vienna, stated that the three cases shown by Mr. Baker were undoubtedly true prurigo of Hebra, and therefore the disease exists in England. The reason of its being often overlooked was that too much stress was laid on the color of the papules, and not enough on its total characters. Prof. Hebra attached much importance to its localization on the outer surface of the extremities, to its increase in severity from above downward, so that the legs were most affected, and to its beginning during the first year of infancy. It does not commence as a papular eruption, but by urticaria, which becomes localized in the second year in the above-mentioned positions; papules now make their appearance, and the disease is established, but we are unable to say whether the case will be prurigo agria or prurigo mitis. Hebra's statement that the disease is incurable requires modification.

Prurigo mitis, when treated from its earliest onset, and for some years continuously, is undoubtedly susceptible of complete, or nearly complete cure.

Dr. Hebra, of Vienna, had often wondered that prurigo was not diagnosed in England, as Willan was the first to describe the affection. He thought that was to be attributed to the fact that attention was directed only to the eczema, without taking into account its cause—excessive itching. Eczema is only *one* symptom of prurigo, and may be absent at the time of examination, especially if proper treatment has been previously carried out. Prurigo must be viewed as a sort of diathesis, which occurs chiefly in badly nourished individuals of the poorer classes, and in the children of tuberculous parents. The papules of the same color of the skin, described by Willan and Hebra, have been lately considered to be due to scratching, and very recently Auspitz has viewed the pruritus and harshness of the skin as caused by a special congenital sensory neurosis. If we bear in mind the well-known feature of prurigo, it will certainly be diagnosed as often in London as in Vienna. Dr. Hebra had already seen several undoubted cases at St. Bartholomew's Hospital. Treatment is only effectual when commenced early in infancy.

Mr. Malcolm Morris, of London, pointed out that Mr. Baker had not mentioned the age to which the disease lasted. Mr. Hutchinson had denied that Hebra's prurigo existed in this country, because no case had been reported lasting beyond the age of twenty-one years, whereas Hebra's prurigo lasted for life.

Dr. Liveing, of London, said he had met with cases lasting to thirty years of age.

Dr. Cavafy, of London, had now one case under his care aged over thirty years.

Dr. Walter Smith, of Dublin, had seen prurigo in a gentleman who is now over twenty-five. He had seen cases of prurigo unaccompanied by eczema.

The President (Mr. Erasmus Wilson) observed that his diagnosis of the cases which had been brought under the notice of the section, by his colleague Mr. Marrant Baker,

was one of chronic eczema—an infantile eczema, which had continued to infest the skin from a very early period of life. Eczema, like other diseases, presented several factors, amongst which two of the most prominent were pruritus and exudation, and these two factors in some sort counter-balanced each other. Now, in the cases before us exudation had ceased, although infiltration was present, and precisely that state of the tissues remained in which pruritus was in excess. This state of the skin would warrant such an appellation as pruriginous eczema, but not that of eczematous prurigo. Prurigo was essentially a neurotic affection, perfectly distinct in its pathological nature from eczema; and it should be the effort of dermatologists to keep them as separate as possible.

Dr. Sangster, of London, would like to allude to the condition of xeroderma noticed by Mr. Baker. He had heard it said that ichthyotic patients were liable to frequent attacks of eczema, and had verified this statement, not in ichthyosis, but in xeroderma, which is its mildest form. He now had a patient under his care whose skin was markedly xerodermic; she is now suffering from eczema, and has not been free from it for some years. Her skin is now thickened and pigmented, especially on the arms. She has a sister who is also affected with xeroderma.

Dr. Bulkley, of New York, thought that a certain confusion had been made between prurigo and pruritus. He would be sorry to have the prurigo of Hebra deprived of its characteristic features as described by Hebra himself, for he believed that the cases seen under this name in Vienna represented a peculiar and well-marked disease, quite different from those met with in other countries. The affection was certainly very rare in the United States, not more than two or three well authenticated cases having been reported, although the disease was known to American dermatologists who had learned to recognize it in Vienna. The speaker had not seen many cases elsewhere which he would be willing to call prurigo; many of those thus called he would denominate papular eczema, while others were but pruritus or pruritus hiemalis. He was familiar with the

affection spoken of as lichen urticatus, or, more properly, urticaria papulosa, and thought that these cases should be very carefully differentiated from prurigo.

Dr. Unna, of Hamburg, said that the description of prurigo vera given by Mr. Morratt Baker and Dr. Liveing completely agreed with the disease as seen by him in Hamburg.

Prof. Oscar Simon, of Breslau, did not agree with Dr. Bulkley that true prurigo is only to be seen in Vienna; it is very common in Breslau and Berlin. The features of the disease are those pointed out by Hebra, who, however, described not only prurigo agria, but also prurigo mitis. He had some years' favorable experiences of pilocarpine in the treatment of this disease; most of the cases either not having relapsed, or only in a slight degree.

Dr. Allan Jamieson, of Edinburgh, asked, since the features of Hebra's prurigo had now undergone some alteration, as described by Prof. Kaposi and Dr. Hebra, whether we might not proceed a step further, and believe that sometimes prurigo might commence late in life, and not invariably in infancy?

Prof. Kaposi, of Vienna, replied that in his experience prurigo never begins in later life. That which is seen in children before the age of two months is not true prurigo, but eczema, and is curable. It is sometimes called prurigo infantum.

Mr. Morratt Baker, of London, replied that he was very glad there was a general agreement among the speakers that the cases which he had exhibited were really instances of Hebra's prurigo, although he regretted that the President of the section took a somewhat different view of their nature. His reasons for believing that the disease was different from lichen urticatus of children were chiefly that he had seen complete and rapid recovery in cases of lichen urticatus, or infantile prurigo, when they were admitted into a hospital, and that the symptoms seemed essentially different when cases of true prurigo and of lichen urticatus of children were compared in patients of like age. He was not disposed to believe that the disease was due to a neurosis only, although the symptoms were

doubtless much exaggerated by the secondary results of the irritation from which the patient suffered. Mr. Baker said he had seen cases of prurigo without eczema, such as those referred to by Dr. Walter Smith ; and he had seen two cases of what he could term nothing else but prurigo, the first symptoms of which occurred in adult life ; the patients were two sisters.

ON THE RESULTS OBTAINED FROM THE EXCISION OF THE PRIMARY SYPHILITIC SORE.*

BY DR. LOUIS JULLIEN, PARIS, FRANCE.

IS it possible to suppress or modify the syphilitic poison by acting in some way or another on the primary lesion, the chancre? Such is the question which is at present occupying the minds of syphilographers. By many writers, such as Auspitz, Kolliker, Folinea, and Unna, it is considered as answered in the affirmative; many are still doubting, while others, guided by theoretical ideas, object to such attempts, and will not even discuss the question, which they regard as already answered in the negative.

The author of these few remarks, although formerly on the side of those who regarded the suppressive treatment of the primary sores as useless, has now somewhat modified his views, and wishes to make his *confrères* acquainted with the results he has obtained from the excision of the primary sore.

Six patients submitted to the operation, but the cases of five alone have been completely followed out. Among these five cases, one alone has remained absolutely free from all syphilitic manifestations. Nine months have now elapsed since the first appearance of the primitive sore, and no secondary accident has shown itself. The chancre was small and evidently syphilitic, and on the nineteenth day was thoroughly extirpated by excision. The wound at first had an unhealthy aspect, but soon was covered with healthy

* Transactions International Medical Congress, London, 1881.

granulations. The inflammatory induration which followed the operation soon disappeared. Scarcely any traces are now to be discovered, and the patient is in perfect health. This, then, may be called the abortion of syphilis, or, at any rate, of its manifestations. One objection only can be brought forward. Was the chancre syphilitic or not? As regards this point, I am able to call Dr. Besnier, of the St. Louis Hospital, as a witness. He saw the patient and made an examination of the piece that was removed, and without hesitation pronounced it to be a syphilitic chancre.

In two other cases the excision was performed on the twentieth and fifteenth day respectively, and in each case was followed by general syphilitic symptoms. The syphilides, however, were indecisive, and the other symptoms were either *nil* or of the mildest possible character. Such results might be considered as favorable to the new method of treatment. I know, however, too well how common it is for the primary sore to be followed by mild secondary symptoms. These two cases, however, scarcely differ from the most ordinary cases, and there are no distinguishing peculiarities. Nothing proves that they were modified by any treatment, and I therefore prefer to exclude them from the list.

It is not so, however, with the two other cases I am going to recount. After the operation, each of them showed a minimum of infection as far as the secondary symptoms were concerned. To these cases I therefore call the particular attention of my colleagues.

First.—Mr. D. was operated upon for a preputial chancre five days after its first appearance. The wound healed by first intention. On the twenty-sixth day cephalalgia appeared, along with a few papules on the abdomen and three herpetiform spots on the dorsum of the penis. At the same time there was swelling of the tonsils along with cervical poly-adenitis. No other accident appeared until the 1st of August, the hundred and ninetieth day of the infection.

Secondly.—I excised from Mr. M. two preputial chancres. The cicatrization took place rather slowly. On the one hundred and third day there was cephalalgia, slight gangli-

onary intumescence, and cervical poly-adenitis. No other symptom until the two hundred and fifth day of the infection.

A syphilis developing itself in this way is so unusual that the reproduction of the same signs, in consequence of the same treatment, must undoubtedly imply something more than a mere coincidence. For my part, I must confess that I have not seen such a form of syphilis, in which, while there was no affection of the skin or mucous surfaces, the lymphatic system alone testified to the presence of the syphilitic poison. I have thus every reason to believe that the excision of the primary sore must account for this modification in the symptoms. I do not think, therefore, that I overstep the bounds of fair inductive reasoning if I call this a case of syphilitic abortion. If, then, these two patients remain free from all further accidents, as I consider they most certainly will, they will no longer be exposed to syphilitic inoculation, and may be actually said to have been vaccinated. This is the point I wished to arrive at, and I desire to point out what an hypothesis it suggests and what a future may be in store for us.

If we do not yet know the means of diminishing the severity of the syphilitic virus, as Pasteur has done with the malignant pustule, it seems probable that we may be able to graduate its effects, by allowing it to develop for a longer or shorter period at the seat of the inoculation. An enfeebled virus may thus be developed, and so act as a preservative against further infection.

I confine myself to these conjectures, as I do not think it would be prudent, on account of the limited number of my cases and my time of observation, to develop them further. I conclude, however, by asking my colleagues to consider carefully the following conclusions :

1. The excision of the chancre causes no local disorder, and hastens the disappearance of the ulceration.
2. Under certain circumstances, with which we are not yet acquainted, it suppresses all manifestations of syphilis.
3. Under other conditions it diminishes to such a degree the effects of the poison that it seems to give the patients the benefit of a real vaccination.

ON THE EXISTENCE OF TWO DISTINCT FORMS OF
ERUPTIVE FEVER, USUALLY INCLUDED UNDER
THE HEAD OF MEASLES, AND THE RELATION TO
THEM OF SO-CALLED RUBEOLA OR RÖTHELN.*

BY DR. W. B. CHEADLE, LONDON, ENG.

ONE of the main points laid down as distinctive of the group of contagious exanthemata, from the time of Cullen downwards, is that each disease occurs in the same individual but once in a life-time—that is, that one attack of any of these eruptive fevers confers in the individual who suffers it immunity from a second ; and the rule has been found to hold good, not, indeed, as absolutely invariable, but with exceptions so few and rare as not to seriously invalidate the general law.

One of the chief members of the group, viz.: Measles has been found to respond to the test with striking uniformity whenever an outbreak has occurred under conditions favorable to exact and comprehensive observations, as, for example, in the two well-known epidemics in the Faroe Islands, when all who had had the disease in the first, without a single exception, escaped the second.¹

Willan² had never met with a case of measles occurring a

* Transactions International Medical Congress, London, 1881.

¹ Dr. Panum, *Archives Gen. de Med.*, April, 1851 ; quoted by Sir T. Watson.

² Dr. Churchill (" Diseases of Children," p. 723, 3d edition) sums up the evidence on this point to the following effect :—Rosenstein never met with a second attack in forty years' experience. Willan and others give the same as the result of twenty years' experience. Dr. Baillie shows it may recur. Dr. Dewees is doubtful, except where the first was rubeola sine catarrho. Eberle mentions one example. Rayer, three cases under his own observation. Guer-

second time in the same person, and Thomas¹ says that a second attack of measles is exceedingly rare, as rare as a second attack of small-pox or scarlatina. I might quote a large number of authorities to show that, although a few exceptions have been recorded, the law holds that one attack of measles affords at most certain protection against a second. My own experience was entirely in accord until a short time ago, when my confidence in this comfortable creed received a rude, although happily, only a temporary shock.

An epidemic of measles broke out in the district of London in which I live in December, 1878. Three of my own children caught the disease, and many other cases came under my observation at the time. The disorder exhibited all the symptoms of true measles. It was ushered in with incessant sneezing, profuse running at the eyes and nose, suffusion of the conjunctivæ, slight hoarseness, frequent but not severe cough, some diarrhœa, plentiful and well marked crescentic eruption coming out on the morning of the fourth day, and a temperature of 102° to 103° or 103.5° during the stage of eruption. In a word, the majority of cases which came under my notice in the epidemic of 1878 were fairly typical examples of measles of more than average severity.

In November, 1879, or not quite a year later, measles broke out in the school to which two of my boys attended, and appeared in a form far more serious than that of the previous epidemic. The boys in question were two of three who had measles in the last outbreak, eleven months before, and I congratulated myself that they at least were safe from attack. But these two supposed protected ones forthwith took the disease, and transmitted it to my three other children, one of whom had also previously had measles in 1878.

Following immediately upon this startling recurrence of the disease in my own family came other instances, show-

sant and Blache give examples of the recurrence of the disease twice in the same year. Churchill doubtful, but gives one example in his own child. Genovesi attended forty-six in Santa Cruz who had had the disease before, and Dubosq de la Roberdière prescribed in 1777 for persons he had treated in 1773.

¹ Ziemssen's "Cyclopædia," art. Measles.

ing in an equally forcible manner the complete absence of any protective power exerted by the previous epidemic.

In two other families, numbering seven children in all, six had measles in the first epidemic, eleven months before, at the same time, and contracted from the same source, as my own children; the seventh had had the complaint a year earlier. These seven children were all exposed in like manner to the contagion of the new epidemic; all took the disease again without exception—not one escaped. Again, three children of another family, under my immediate observation, who had had measles of a severe type three years previously, were exposed to the contagion of the second epidemic, and from the same source as those above mentioned all took the complaint and had it severely.

Thus it came about, that, of the first fifteen cases of the second outbreak that came under my notice, no less than thirteen had had measles before, and nine of the thirteen under my own eye within the year.

Altogether I have been able to obtain a trustworthy history of thirty cases. Of these, eighteen came under my own observation at the time; the remaining eleven, although not seen at the time of eruption, occurred in individuals with whom I am acquainted, have been carefully investigated, and are thoroughly reliable. Out of this total of thirty cases of the second epidemic, twenty-two had certainly had measles previously. The protected individuals suffered equally with those who were exposed to the contagion for the first time. They took the disease just as readily; they had it just as severely.

At the outset of this second epidemic the character of the exanthem was one of grave and even dangerous type.¹ No instance in which the disease proved fatal to an individual previously healthy came under my own observation; but in three cases under my care the condition was for some time critical; and four deaths occurred in children suffering from other diseases at the time. Three were killed

¹ The first twenty cases might be classed as severe; the remaining ten, all occurring at the close of the epidemic, were of milder type, and in some the constitutional disturbance was extremely slight.

directly by the measles during the eruptive stage; the fourth died from the effects of broncho-pneumonia set up by it.¹ The course and symptoms of the disease in this second epidemic of 1879 showed appreciable variations from those of the disorder which prevailed the year before, which might be taken as a typical example of the ordinary form. Yet it may be said, I think, that all the phenomena were such as have been described at one time or other, as arising in the varying phases of true measles, and the outbreak was generally regarded, without question, as genuine measles of an unusually severe kind. If that were so, then in all cases previous attacks of measles absolutely failed to give the protection which experience proves them to confer, almost without exception, against a second attack of the same disease. It is impossible to accept this solution without question. The suspicion arises that the disease of the second epidemic, although at first sight apparently identical with measles, might in reality be as specifically distinct from it as typhus from typhoid or variola from varicella. Slight differences may indicate a generic distinction, marked by a general superficial agreement in more obvious characteristics, and a careful analysis of the phenomena of the second epidemic shows certain points of difference and some special features which, taken together, lend support to the theory of its specific distinctness.

I. *The Period of Incubation.*—This was accurately ascertained in two cases where there was a single exposure to infection limited to a few hours. In one,² the first symptoms showed themselves the eighth day; the eruption on the eleventh. In the other,³ the first signs were observed on the ninth day; the eruption was out on the morning of the twelfth day after exposure.

The period of incubation was ascertained approximately in five other cases. In two,⁴ where the exposure lasted

¹ Three cases of empyema (two convalescent) and one of tetany.

² L. M., exposed for a few hours, November 22, 1879. First symptoms, November 30. Rash, night of December 2-3.

³ —, child in Great Ormond Street Hospital, exposed January 7. First symptoms, January 16. Rash, night of January 18-19.

⁴ W. W. C. and F. M. C., exposed to contagion, November 11, 12, and 13. (Rash out in infector, 13th). First symptoms in two infected, 21st. Rash out in two infected, 23d.

three days, this could not have been more than twelve days, or less than ten, the period from eruption to eruption being ten days; and in the remaining three,¹ the period from eruption to eruption was uniformly twelve days.

No opportunity arose for testing the incubation period in the first epidemic, but I have ascertained it in two cases of ordinary measles where there was a single short exposure.² The first symptoms were observed on the tenth day; the rash appeared in both instances in the night between the thirteenth and fourteenth days. These conclusions are in exact correspondence with the observations of Panum in the Faroe Island epidemics, and are confirmed by other accurate records, as shown by Thomas in a very complete examination of the subject.³

The period of incubation in true measles appears to have a duration of extreme constancy, viz.: thirteen to fourteen days to the appearances of the eruption, and usually, but much less uniformly, of ten days to the first symptoms, so that in the epidemic we are considering the period of incubation was shorter than the normal one of true measles by from one to two days.

II. *The Period of Invasion* was also shorter than normal by a day, although, as this appears to be liable to variation in true measles, much stress cannot be laid upon the difference in the eight cases in which this point was noted with exactness. In seven the rash appeared on the third day after the initial symptoms⁴; in the eighth,⁵ (one of empyema), not till the sixth day after access of febrile symptoms, but the twelfth after exposure.

III. *The Catarrhal Symptoms and Affection of the Air Passages* exhibited certain special features. There was in-

¹ Ashwell Coates, Perkins (empyemas). Eruption in infector, November 10; in infected, November 22.

² W. F., visited Brighton for a few hours. Exposed to measles contagion. Sickened tenth day. Rash thirteenth to fourteenth day.

Una B., slept one night with girl with measles. Sickened tenth day. Rash thirteenth to fourteenth day.

³ Ziemssen's "Cyclopædia," art. Measles.

⁴ W. and F. C., L. M., L. and M. F. (private cases). Coates, Perkin's (Children's Hospital).

⁵ Ashwell (Children's Hospital). Exposed November 10. First symptoms, November 17 (rise of temperature to 100.8°, continuing up to eruption).

jection of the conjunctivæ; usually slight sneezing at the outset, which soon passed off; little running at the eyes and nose, in many cases none; no intestinal flux. On the other hand, the hoarseness and irritation of the throat were extreme, and cough incessant, laryngeal, croup-like. In one instance this was harassing beyond anything I have ever seen. The patient (a boy 10 years old) could not be kept in bed, but stamped about the room in distress, so intolerable that chloroform had to be freely given to relieve it.

In one case the respiration became difficult and stridulous; the tonsils, fauces, and soft palate were dusky red, much swollen, and covered with tenacious mucus. Enlargement of the glands at the angle of the jaw was observed in one or two instances. In one there was a film of coherent membrane on the tonsils, and albumen in the urine.¹ Marked bronchitis, evidenced by sibilant respiration and abundant fine rales at the bases, was present in all but the mildest cases. In two broncho-pneumonia supervened.

The contrast between the two epidemics in regard to these symptoms was striking. In the first, incessant sneezing, coryza, lachrymation, comparatively slight hoarseness, frequent, but not severe cough, some diarrhœa. In the second, little or no sneezing, coryza, or lachrymation, extreme hoarseness, incessant croup-like cough, marked implication of the larynx and bronchi, entire absence of catarrh of the intestinal mucous membrane.

IV. *The Eruption* presented some points of divergence from the normal measles' rash. It was more raised, more coarse and papular; the grouping of the stigmata was not crescentic, but in irregular blotches, and of a darker, more purple hue. In the severest cases it was confluent on the face and backs of the wrists and hands, accompanied with much swelling. In one instance there were petechial and small purpuric patches on the extremities; and in this case

¹ In an epidemic of measles, which prevailed contemporaneously at Folkestone, and which probably was of the same generic form, the affection of the throat was equally prominent. I learn from Mr. Tyson, of that town, who has kindly written to me with this information, that in three cases the laryngeal obstruction was so great that tracheotomy had to be performed; in another the operation was threatened, and that other cases of a similar kind had occurred.

the livid papular petechial rash and the swollen hands and feet bore, at first sight, a strong resemblance to the condition in severe small-pox.

In two instances of more moderate intensity, but contracted from one of the more virulent cases, the confluent eruption on the face and limbs, in place of being purple and papular, was diffuse and rosy—closely simulating in these points the rash of scarlatina—elsewhere of the patchy, purple, measles form. In all these cases the eruption did not reach the maximum until the third day, the most intense not beginning to decline until sixty hours, or even more, after its first appearance,—*i. e.*, at the close of the third or beginning of the fourth day.

V. *The Eruptive Fever* ran high. The temperature went up to 103° as the rash came out, and continued to rise a little until the eruption reached its height, and ran up to 104° , or 104.5° at the maximum. In the majority of instances the temperature began to fall on the fourth day of eruption; but in two, in which there was no complication, it remained at 103° to 104° for two days later, or the fall did not fairly commence until the sixth day.

The pulse ranged from 130° to 160° at the maximum. In one case (A. C.) without complication, it remained 130° to 140° for forty-eight hours after the eruption reached its maximum, and was feeble and irregular.

During this period the tongue was much coated and became dry; there was night delirium; and, as the eruption came out, drowsiness extreme beyond all precedent, lasting for some days after the rash reached its height.

VI. *Vomiting* was another salient feature present in all the severe cases. It was noted in thirteen, and generally showed this peculiarity: In some instances it began with the first fever, and recurred at intervals until the eruption declined; but more usually it did not usher in the initial symptoms, as in most eruptive fevers, nor occur later in the stage of invasion *before* the appearance of the eruption, as observed sometimes in true measles, but *afterwards*, during the eruptive stage and most commonly about the second day. This vomiting was not the result of the violent

cough, but quite independent of it—a distinct effect of the measles poison.

VII. Another symptom, present in all severe cases, with a constantcy I have never observed before, was *ear-ache*. It was noted in ten of the cases, of which I had personal knowledge, and may have occurred in many more, of which I have less complete records. It came in, with the greatest uniformity, about forty-eight hours after the eruption began to decline; lasted with much severity for several hours, and then disappeared. In no case was there any discharge from the external meatus, and only in one case persistent deafness afterwards.

Such were the symptoms observed in severe cases in the earlier part of the outbreak of 1879. Toward its close, the cases which arose were of exceedingly mild type. The period of invasion was extremely short, often not more than twenty-four to thirty-six hours, marked only by slight malaise, catarrh, hoarseness, and cough; little or no sneezing, or flux from the eyes and nose. The temperature rose to 101° or 102° for a short period as the eruption came out, with rapid defervescence. The patients, in marked contrast to those attacked at the outset, were hardly ill.

The special features observed in the epidemic of 1879, added to the evidence afforded by the absence of any protection conferred by previous attacks of common measles, confirm the view that the disease in this outbreak was specifically distinct. And if so, the question arises whether it is a new and previously unrecognized exanthem, or a severe form of so-called German measles, rubeola or r  theln.

At first sight the supposition that it might be r  theln would seem to be negatived by the great severity of the majority of cases.

As far as my researches go, authorities who recognize it at all are almost unanimous in regarding it as a disease of uniformly mild type.

It is said, indeed,¹ to be specially distinguished from true measles by its slightness and want of character.

Trousseau² estimates it as the mildest of the eruptive

¹ Bristowe's "Theory and Practice of Medicine," p. 153.

² "Clinique Medicale," Sydenham Soc. Trans., vol. ii, p. 237.

fevers, standing in the same relation to measles as chicken-pox to small-pox.

Vogel speaks lightly of it as without fever or catarrh.

And thus, throughout the whole list of writers on the subject,¹ except Aitken,² who states that fatal cases have occurred, and describes *post-mortem* appearances.

Now these descriptions of the characters and symptoms of r \ddot{o} theln apply accurately enough to the slighter cases toward the close of the second epidemic, but to them alone.

On the other hand, there is an obvious resemblance between the severe cases and those described by authors as a malignant form of common measles—the rubeola nigra of Willan, the rubéole boutonneuse and ecchymotic measles noted by Trousseau,³ and the similar variety graphically described by our President, Dr. West.⁴

So that, in this epidemic in question, we have cases in the first fierceness of its outbreak corresponding closely with those ordinarily classed as abnormally grave and exceptional cases of common measles, and later others of less marked characteristics, directly bred from and lineally descending from the first, corresponding in all respects with those regularly recognized as rubeola or r \ddot{o} theln.⁵

Not only were the mild cases occurring at the time of the epidemic in West London generally regarded as r \ddot{o} theln, but r \ddot{o} theln was present at the time, shortly before or shortly

¹ Wunderlich ("Temperature in Disease") says the elevations of temperature are generally sub-febrile, or, at the most, moderately febrile; and that although in isolated cases more considerable elevation of temperature may be met with, they depend no doubt either upon complications or on that peculiar mobility of temperature characteristic of very young children.

Thomas (Ziemssen's "Cyclopædia," art. Rubeola) states that in the majority of cases there is no fever, but that the course of the temperature is a varying one. There are cases with fever and rapid initial increase, *with defervescence at or before* the disappearance of the eruption.

² Aitken, "Practice of Medicine," art. R \ddot{o} theln.

³ Trousseau, "Clinical Medicine," Sydenham Soc. Trans., vol. ii, p. 216.

⁴ "Diseases of Infancy and Childhood, 6th edition, p. 808.

⁵ L. M., a boy of six, caught the disease by a solitary exposure of three hours to the contagion of two of the most extreme cases under my observation. He had the exanthem severely, and of the same form as those from whom he took it. He communicated the disease to two sisters; in them the eruption was less severe, and had all the features of typical r \ddot{o} theln, *i. e.*, roseolous eruption on the face and extremities, elsewhere measles-like; no catarrh; red, swollen fauces; some tumefaction of the glands under the jaw.

after, in various parts of the country, as appeared from numerous reports published in the medical journals at this juncture.¹

Further, the severe cases agree in character with that which we would naturally expect an intensified rōtheln to present: Coryza slight or absent; papular non-crescentic rash, in some cases confluent on the face and extremities, sometimes scarlatiniform there; prominent throat symptoms; absence of intestinal affection; in some cases enlargement of the glands at the angle of the jaw; with a shorter period of invasion and incubation than in ordinary measles. *The general features the same as in recognized rōtheln, but certain of them increased and exaggerated.*

It seems impossible to avoid the conclusion that the disease in the second epidemic, which I have described, was that variously known as rubeola, epidemic roseola, or rōtheln, which exists not only in the slight and unimportant form generally recognized, but as an eruptive fever of considerable severity, which may assume a dangerous, and even malignant type.

No other hypothesis will, to my mind, explain all the facts which I have adduced.

As rōtheln is distinct from true measles so, I believe, is it distinct from scarlatina. Eight of the cases recorded had, to my own knowledge, previously suffered from scarlatina, and it has been shown repeatedly by others that previous scarlatina possesses no more protective power against rōtheln than a serious attack of measles.

No connection has been traced between rōtheln on the one hand and scarlatina and measles on the other. The hypothesis that rōtheln is a hybrid between the two, rests on no better foundation than that it presents certain superficial points of resemblance to each of them.

Finally, as the outcome of these observations, I would venture to draw the following conclusions:

¹ In Manchester, February 1880, Dr. Tomkins, *Brit. Med. Jour.*, May 29, 1880.

In Bradford, end of 1879 and beginning of 1880, Dr. Burnie, *ibid.*, June 5, 1880.

In Bolton, spring of 1880, Dr. Robinson, *ibid.*, June 19, 1880.

In Exeter, spring of 1880, Dr. Wordman, *ibid.*, June 26, 1880.

In Wansford, autumn of 1879, Dr. Brown, *ibid.*, July 3, 1880.

1. That r  theln is a specific contagious exanthem, distinct from either measles or scarlatina.

2. That the period of incubation is from eleven to twelve days; the period of invasion from two to three days; but in mild cases this may not be more than twenty-four hours. On these points, however, more extended observations are desirable for their precise estimation.¹

3. The other features, which, not singly, but taken together as a clinical proof, may serve to distinguish severe cases of r  theln from severe cases of ordinary measles, with which they are liable to be confounded, are :

The slightrness or absence of sneezing and coryza.

The greater severity and frequency of the cough ; its hoarseness and laryngeal character.

The more marked catarrh of the larynx and bronchi.²

The absence of intestinal catarrh, as evidenced by absence of diarrh  a.

The more papular character of the eruption; its more purple hue, the absence of any crescentic arrangement, its confluence on the face and extremities, where, in such case, it may be swollen, purple, purpuric, or scarlatini form.

The higher range of temperature and its longer persistence.

The extreme drowsiness during the eruptive stage.

The occurrence of vomiting when the eruption approaches its maximum.

The occurrence of earache during its decline.

In addition to these more constant symptoms, there may be, in extreme cases, exudation on the fauces, and probably in the larynx, and albumen in the urine.³

¹ The incubation period of r  theln appears to be not clearly ascertained. Bristowe ("Principles and Practice of Medicine") says about one week. Aitken does not state it. Thomas says it is uncertain, but probably two and a half to three weeks.

² Aitken ("Practice of Medicine," art. "R  theln") says the throat is sometimes so swollen that fluids regurgitate through the nose in swallowing, and that in fatal cases death occurs from coma or bronchitis.

³ In addition to the case noted by me, Dr. Duckworth (*Lancet*, 1880, vol. i.) reports one in which there was transient albuminuria of probably three days.

ON RUBELLA; RUBEOLA SINE CATARRHO; RÖTHELN, OR GERMAN MEASLES.*

BY DR. WILLIAM SQUIRE, LONDON, ENG.

THIS exanthem, popularly known among us as “false measles,” has been mentioned by various writers under the above names, or as rubeola notha, spuria vel incocta, and sometimes as epidemic roseola, for the last hundred years.

A century was required to complete the separation of measles from small-pox. Another century passed from Sydenham to Withering before scarlet fever was finally distinguished from measles. The disease in question has but a superficial resemblance to scarlet fever; its relations are clearly and closely to measles or rubeola as defined by Sauvages and Cullen. The century is fulfilled that should give autonomy to rubella.

Whether introduced by the Moors into Spain and Italy in the eighth century, or only first described by the Arabian writers is uncertain. Their name of Hrasbah included both measles and scarlet fever, and gave origin to our comprehensive word “rash.” It was included with scarlet fever by Sydenham, and consequently considered a slight ailment. We know that it was so included by Richard Morton (*Πυρετολογιας*, 1694) where scarlatina is spoken of as a mild form of scarlet fever, and a case of scarlet fever is given as “confluent measles.” Hildebrand imagined it to be a true hybrid between scarlet fever and measles, in a way which those who now heedlessly adopt his view would

* Transactions International Medical Congress, London, 1881.

hardly contend for. Bucholz mentions the long incubation. Heberden speaks of measles without fever or precedent catarrh. Willan named it *rubeola sine catarrho*, noticing that it did not protect from measles. Bateman confirms this (Synopsis, Lond., 1813), and makes it a new febrile variety of rubeola. The name *rubeola sine catarrho* is objected to by Mason Good, as the genuine measles themselves, capable of affecting emancipation, have sometimes appeared with very slight catarrhal symptoms. He says it has been called, and especially by the German writers, spurious measles, but as it occurs more frequently when the genuine measles are epidemic, it is less properly a spurious than an imperfect or immatured rubeola. His prejudice for this being merely a variety of measles, and not itself an independent exanthem, prevented a right judgment being formed on the series of cases observed by Dr. Maton, already before him, which he considered to be varieties of scarlet fever, though distinguished from it by a long incubation period,—a character he notices to belong to certain cases of measles reported by Bucholz when the “efflorescence evinced a little procrastination, and appeared as late as the twenty-first day.”¹

To Dr. William George Maton, F.R.S., Physician-extraordinary to Queen Charlotte and a Fellow of our College of Physicians, is due the merit of discriminating the exanthem in question both from measles and from scarlet fever. In a contribution to the *Medical Transactions* of the College, vol. v, p. 149, London, 1815, Dr. Maton says that, having several times seen cases called either scarlatina or measles, in which the symptoms of illness were trivial and the external characters insufficient to decide their nature, he determined to keep a scrutinizing eye on all similar cases. Then follow a series of eight cases. The first is a girl of 13, who on August 18, 1813, had this rash; her face suffused with innumerable points, but she did not feel ill. A sister with her complained slightly, and had some fulness of the small cervical glands; next day she had the rash. In the room with these two sisters were four others of the family, aged

¹ The Study of Medicine, London, 1825, vol. iii, p. 16.

from 10 to 17 years; two of these had the rash on September 4th and 5th, the other two on the 7th of September. Two other relatives, the eldest brother, aged 24, and his infant son, a year and a half old, were taken on September 24th and 30th. Dr. Maton remarks: "There is only one other exanthem that I know of to which these cases can be considered referable, that is, roseola; but tumors do not occur in roseola, nor is it infectious. The period intervening between the application of the infectious influence and the commencement of the disease was considerably longer than has been noticed in scarlatina. Hence, it seems requisite to form a new designation, which, however, I do not venture to propose at present, being satisfied with calling the attention of my colleagues to the subject." It is needless to summarize all the notices of the disease from Dr. Babington to the present time (Trousseau, *Edinburgh Med. Journ.*). It has been long enough under general notice to deserve a name, and may well receive from the present International Congress a distinctive appellation, which Dr. Maton so wisely chose to defer. He has summed up all the characteristics of the disease in these few cases—the contagious property, the long incubation, the enlargement of the small cervical glands. All that subsequent observation has done beyond confirming these characters is to show that the disease is self-protective, and, in fact, possesses all those qualities of an independent and specific disease so well summed up by Sir Thomas Watson in the case of varicella, when he says: "This may be a very trivial disorder, but it is stamped with the characters peculiar to the group. It is contagious; it runs a definite course; it occurs but once in the same person." Of two allied diseases, the slighter form is more slowly recognized and distinguished. After the separation of measles, small-pox and varicella were long associated; but no one now doubts, however modified, their absolute distinction. Since the clear definition of scarlet fever, measles is found to have a near ally, as near as chicken-pox is to small-pox. Their gradual differentiation is brought about in the same way. The fever is observed to be less in the one than in

the other; the severer disease affords no immunity from the slighter ailment, nor is that in any way protective against the other, while each is self-protective from recurrence. The difficulty of establishing those points may seem to be out of proportion to the practical good to follow; but definite ideas as to the course of the milder ailments, and of the effects produced by them, have important bearings, both as to the care of those attacked as well as on the safety of others, and all that can be collected concerning them is deserving of careful record.

Rubella then, may be defined as a specific eruption, the rash appearing on the first day of the illness, beginning on the face in rose-red spots, extending next day to the body and limbs, subsiding with the fever on the third day, and rarely either preceded by catarrh or followed by desquamation; the former never for three days before, the latter never after three weeks. Propagated by contagion, it occurs in epidemics of limited extent, with sporadic offshoots. It has a long period of incubation, mostly a fortnight, the extreme being twenty-one days, hence a difficulty in tracing the source of personal infection. This is increased by the slight and transient nature of the infection alluring patients to mix freely with others. Cases have been noted where the incubation may possibly have been as short as five or seven days.

One attack is preventive of a recurrence, but is not protective against either measles or scarlet fever, nor do attacks of either of those diseases in any way modify the liability to this one; it is as distinct from them as chicken-pox from small-pox. During epidemics of measles or of scarlet fever, mild and irregular cases of both are not unfrequently mistaken for this exanthem; well-marked outbreaks of it are often attributed to measles, while slight attacks of scarlet fever are miscalled r  theln, or a hybrid disease imagined, which has no existence. Young infants are said to escape; adults not infrequently suffer, as many persons escape attacks in childhood; sex makes no difference. The disease is contagious even before the rash is thrown out, and it continues to be so for some days, or it may be for two or

three weeks afterward. Second attacks are rarer than for scarlet fever, but the rule against them may be less absolute than for measles. It is seldom fatal. When a mortality of attacks is reported as high as three per cent., measles is probably the epidemic present.

Slight fulness of head, heaviness, pain or giddiness is felt, with a little aching of back and limbs, or tenderness of throat for a few hours on the evening before the rash appears. The cervical lymphatic glands are always perceptibly enlarged, and sometimes have been so for a few days before the rash appears. Mostly the rash is first seen with surprise, as the feeling of illness has already passed, and may have escaped notice. There is redness of the fauces or uvula; less mottled than in measles, not so intense as in scarlet fever; the tonsils are rather full and smooth; there is no ulceration. The eyes are suffused, but there is little or no coryza; the lids are somewhat swollen and irritable; the face is flushed, and the cheeks red or full, even before the appearance of the spots; these are bright red, raised, rounded, with clear skin between them, but they soon coalesce; not grouped as in measles, the spots are more prominent than in scarlet fever, and there is not the finely diffused redness of the neck and chest as in that disease. Moreover, the rash is already fading from the face, while extending to the limbs. Sometimes an odor as of measles attends the rash. Some itching or a very fleeting yellowish tinge, but no discolored mottling of the skin is left, and no desquamation, except of the branny kind, which occurs early, and is never delayed to the third week. However, little illness is felt at the beginning, a continuous rise in the temperature commences with or just before the rash; it may reach 102° to 103° , or be only two degrees above the normal. With rest in bed this may fall one degree by the end of the second day, but is evenly maintained as the eruption proceeds, or subsides with it on the third day. During the following week it is readily disturbed, either raised by exertion or depressed by fatigue or chill. At this time recrudescence of the rash has been observed. Slight coryza may come on after the rash has faded, the

eyelids become sticky, the nostrils stuffed, the throat sore, or some cough begins. Exposure or want of care at this time may determine serious disturbance of health, generally with pulmonary complications. The urine is often high colored in the early part of the illness; the chlorides are increased, but there is no albuminuria, nor has this ever been known to follow. In some few cases transient complaint of the throat or of fatigue has been made a week before the rash, or epistaxis has occurred; fulness of the small cervical glands is often felt, but no constant intermediate symptoms are found, and any feeling of sickness is without fever.

The sudden onset of this form of rubeola without previous sneezing or cough distinguishes it from measles, to which it is much more nearly allied, as well by general characters as by the kind of rash, than to scarlet fever; but the spots are more evenly distributed, often at wider intervals, and not in groups. There is no gradual rise of temperature before the rash, nor the sudden fall afterward, both characteristic of measles. The small lymphatic glands are palpably enlarged in this ailment down the sides of the neck, and perhaps behind the ears, but not specially at the angle of the jaw, as in scarlet fever. The rash on the second day may look like scarlet fever, or the red flush of scarlet fever, at first sparsely distributed or with prominent red papillæ, may lead to mistake; but the sudden onset is much more marked in scarlet fever, when, should the rash appear as early, it will be more intense on the third day, especially on the neck and chest. Moreover the fever persists till the fifth day in scarlet fever, even when not greatly elevated; there is also the state of the pulse and tongue, or the prominence of throat symptoms. Sometimes it is not till the second or third week that the kind of desquamation and possibly signs of renal irritation or the occurrence of other cases complete the diagnosis. The length of interval between succeeding cases is also a distinction. Roseola is not contagious; it occurs in red points or spots not raised above the healthy skin between; there are no throat symptoms, no enlarged lymphatic

glands, nor fever. Erythema effects parts of the skin only. Attention restricted to the character of its eruptions often leads to error.

Recovery is so much the rule, that were it not for the mischief any febrile disease may excite in weakly children, the risk of pulmonary disease from close confinement during the rash, or from premature exposure afterward, all cases of rubella might be expected to do well. In all cases look to the throat and examine the chest. Two months may elapse before health is quite restored. It is not always the trivial disease so often met with. In any large number of cases some will develop unusually high temperature, just as is seen in varicella; and in others slow convalescence or deterioration of health is dated from this accident. This is due to the individual state or conditions, and not to change in the nature of the disease; it is seen with equal severity in those who have, as in those who have not, had measles previously. Where persons are said to have had measles twice, one of the attacks has been of this kind. A more serious mistake is often made in passing slight cases of scarlet fever under this category by the name, perhaps, of a rose rash or a roseola, instead of rubeola or rötheln. Such terms as roseola or even rosalia, by which scarlet fever has been called, should be expunged from the nomenclature of the contagious exanthemata. Whether there be a distinct variety of scarlet fever concealed under the disease, as now known, is not under consideration. Scarlet fever and measles, scarlatina and rubeola, belong to different types of diseases; the one of short incubation, sudden ingress, and slow decline, with special tendency to throat and kidney mischief; the other of long incubation, gradual ingress and sudden decline, with tendency to bronchial rather than to renal irritation. It is to this latter, the order rubeola, that the disease under consideration clearly and undoubtedly belongs. I would suggest that, as representing the allied but distinct form of rubeola, the diminutive of this word, "rubella," as already proposed in the United States by the American Dermatological Association, should receive the sanction of this International Medical Congress for general use and adoption.

Clinical Reports.

CLINICAL ILLUSTRATIONS OF DISEASES OF THE SKIN.*

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X. **Acne.**—In the preceding article the diseases of the sebaceous glands which manifested conditions of faulty secretion and excretion, were considered, namely, acne sebacea or seborrhœa, and acne punctata or comedo. Attention will now be given to the inflammatory conditions involving the sebaceous glands which are more commonly recognized as acne, namely, acne simplex, acne indurata, and acne rosacea. All of these may at times be associated in the same individual, and not uncommonly one or more of the forms of functional sebaceous disturbances are also present; acne punctata or comedo is usually present to a greater or less degree in connection with acne simplex.

ACNE SIMPLEX.—Synonyms: *Acne vulgaris*; *Acne juvenilis*; *Acne disseminata*. Probably very few persons escape from having

* The very favorable reception which was accorded to the "Notes on the Local Treatment of Certain Diseases of the Skin," until most of the diseases which are at all common were gone over, in previous issues of these ARCHIVES, leads the editor to continue this plan of serial writing for general practitioners in the form of "Clinical Illustrations of Diseases of the Skin." It is intended in these to give plain and practical comments on dermatological subjects, based on illustrative cases taken from private and public practice, some of the matter at times being that delivered in clinical lectures at the New York Hospital. The diseases will, as far as practicable, be treated of in the order in which they occur in the classification commonly found at the beginning of the Digest Department. These notes are continued from pages 60, 139, 261, and 399, volume vi; from pages 162, 301, and 403, volume vii; and from pages 29, and 130, volume viii.

some amount of acne at some period in their youth ; that which may be manifested on some individuals as a few scattered pimples, or a single one, following a gross indiscretion in diet, will in other cases exhibit such an amount of diseased action in isolated, or grouped, or thickly sprinkled inflammatory points as to result in a serious deformity and to call for active interference. Acne simplex is decidedly a disease of youth, and may be said almost never to occur in childhood or old age ; but it may appear a little before puberty and may frequently be observed far into middle age. While in the majority of persons it has a tendency to disappear sooner or later with improvement in health or a little attention to diet, in many others it becomes a most persistent and annoying disfigurement, which greatly mars the happiness of the patient and parents, and it may prove very rebellious even to carefully directed dietary and medicinal treatment.

In many cases the acne seems to be only one manifestation of debility, and the failure of the sebaceous glands to properly secrete and excrete, and their consequent blocking up and inflammation seem to be but a part of the general want of tone of the system, as is exemplified in the following case :

Miss S., aged 16, the daughter of a physician, was referred to me April 19, 1881, on account of an eruption of acne, principally on the forehead. She was a rather pale and delicate looking girl, who had been a good deal subject to headaches, and had suffered more or less from malaria. She was habitually constipated, with chalky passages, the menses regular and not excessive. The eruption had begun two years previously, and had always been worse at the time of menstruation and just after. She was given a pill of aloes and iron, alkaline baths, and the following lotion : \mathcal{R} Potass. sulphuret ; zinci sulphat. \overline{aa} 3 i ; aquæ rosæ $\frac{3}{4}$ ii ; \mathcal{M} ; to be applied night and morning. Some days later she was placed upon a tonic mixture containing iron, nux vomica, a little arsenic, and compound tincture of cinchona. Under this treatment there was very marked improvement, although she had worked very hard at boarding-school. In the autumn, there being still a little eruption, she was given an alkaline mixture, with the effect of clearing up the skin.

It has repeatedly happened during the treatment of acne in young persons that more improvement will result when the patient is placed on an iron and bark mixture than has been obtained from various other treatments ; this is not so commonly the case in those who are older, and not infrequently iron tonics will aggra-

vate the eruption, especially is this true of the indurated and roseaceous forms, to be spoken of later.

Mrs. R., aged 26, first consulted me December 18, 1879, at the request of Dr. Marion Sims, under whose care she was for erosions of the cervix. She was delicate, and rather nervous, pulse 90, and weak, tongue pale and indented. She had one child five years old, which she had nursed in part for nine months. The eruption had appeared on the face fully three years previous to her visit, and she had never been entirely free from it, although it had been much less the preceding spring.

When first seen the entire face, nose, forehead, and chin were the seat of a very abundant eruption of papules, pustules, and intermediate redness, with some scars and stains of preceding eruption; the face felt hot and tense, and occasioned her much trouble by its unsightly appearance. The bowels were constipated, and she depended on rhubarb. A pill of aloes and iron was prescribed to be taken after each meal, and the same lotion given as in the former case; she was also directed to soak the face once daily, at bed-time, with hot water, by means of a handkerchief, for from three to five minutes. Very strict dietary regulations were also enjoined.

Six days later, it was recorded that the face was decidedly better, the redness had diminished very materially, and some of the single points had disappeared. The pills had acted very considerably, and one pill, after the evening meal, was found to be quite sufficient. The same treatment was directed to be continued, and sulphide of calcium was ordered, in quarter-grain doses, four times daily between meals. The benefit from this was also decided, and it was continued for some weeks; it then seemed to lose its effect, and she was given acetate of potassa in the following combination: \mathcal{R} Potassii acetatis \mathfrak{z} i; tinct. nucis vomicis \mathfrak{z} ii; extracti rumicis rad. fl. \mathfrak{z} iii; \mathcal{M} . Teaspoonful half an hour before eating, well diluted. The gain from this was also decided, and it was continued off and on for some months, with the occasional alternation with iron, quinine, and strychnia tonics. Six months after the first visit, it was recorded that the face was perfectly well, all the eruption had disappeared, and even the stains left by the spots had almost vanished.

In this case the eruption did not remain absent after its disappearance; the patient has been under observation and treatment repeatedly since, there being occasional recurrences whenever she becomes run down. In connection with the acne she has always had much trouble with the eyes, in the way of corneal ulcerations and styes. These had received much local treatment previous to her coming under my care, but with little benefit; under the treatment for acne these ceased, and the eyes are in better condition than for years, without any local medication. With each period of exhaustion or debility, however, fresh lesions would occur in the eyes as well as upon the face.

Acne simply seems to be more difficult of complete removal in young males than in young females, and will often persist most rebelliously in spite of varied and suitable treatment, internal, local and dietary. It will then sometimes cease quite suddenly, without apparent known cause. I have never been able to trace any connection between the eruption and masturbation, although when carried to an excess, producing debility, it undoubtedly aids in developing acne and rendering it rebellious.

In many cases in young men, the functions of life will all appear to be performed in the most perfect manner, the health and strength is apparently excellent, and the diet may be all that can be desired, and yet the eruption will persist and resist all measures most annoyingly. The following case exhibits well the ordinary acne as it commonly affects young men.

Mr. E., aged 19 years, was referred to me February 2, 1879, for the treatment of acne simplex which gave him much annoyance. He had always enjoyed good health, and bore every appearance of being well; he had light hair and complexion, with rather a doughy, pasty skin. The digestion was reported as perfect, the bowels acted daily, the urine was normal.

The eruption had began in the Autumn, three or four months previous to his visit, after he had been confined very considerably with hard studies; it had increased during the winter, and was then at its height. The whole face and forehead was sprinkled with papules, pustules, and comedones, causing a very unsightly appearance. He was given directions in regard to diet and exercise, and sulphide of calcium in pills, one quarter grain four times daily, on an empty stomach. The following lotion was also prescribed: \mathcal{R} Sulphuris precip., 3 ss; etheris sulphurici, 3 iv; spts. vini rectificat., \mathfrak{z} iiiss, \mathfrak{m} ; to be well applied at night, and also once or twice during the day.

One week later there was a marked improvement, the papules and pustules had much diminished; many comedones were extracted, and the treatment continued the same. The improvement was still noted at subsequent visits, and by the end of a month there was hardly any of the former eruption to be seen, but the skin did not return to a wholly normal condition; he continued to be very much confined in studies, and in laboratory work, with chemical assays, etc. In the following autumn he was again seen; he had been at the seashore, and then in the Adirondacks, had had occasional boils, and on return to work his acne again appeared quite severely. He was then given a mixture of acetate of potassa, nux vomica, and rumex, as he exhibited some digestive disturbances, and later was put upon a tonic of iron arsenic, nux vomica, and bark. The general health improved considerably, but in spite of various local applications, strong and

mild, the eruption lingered to a greater or less degree on the face, although he gave care to it, and followed treatment very carefully.

At one time he had nose-bleed to a troublesome degree: for this he was given ergot in full doses, in the hopes that it would also prove beneficial to the acne, as it had been recently recommended for this. But although it checked the nasal hemorrhages and was continued for some time after, the effect upon the acne was hardly appreciable, and not equal to that obtained from other remedies. This gentleman has been seen with more or less regularity for some time, but at the last note there was still a production of acne points from time to time, especially whenever he became in the least degree run down from confinement and overwork.

Acne in young persons is not very infrequently found to be thus rebellious, and some writer has remarked that the only permanent cure of the eruption is senility. While this latter remark is not true, it contains a suggestion which it is well to heed. Undoubtedly the formative and developmental period of life about the age of puberty is that in which the eruption is mostly observed, but as it is also often seen much later in life, and is found to depend so largely on digestive and other elements, we are to look for its causation beyond the mere structural changes in the skin which are associated with puberty, as the development of the hair, adipose tissue, etc. During this period of youth the strength is apt to be overtaxed by excitement and work for which the young frame is unfitted, and simple debility is a most common state to be found in those with acne at this period, and the failure in the gland cells to carry through the process of liquefaction results in a blocking up and consequent inflammation of the follicles.

Another element to be considered is the fact that during this early period of life the temptation of the appetite is very great, and young people are continually indulging in cake, candy, nuts, and a thousand articles which are capable of exciting digestive disorders, or of producing blood changes which result in elements which poorly nourish the tissues, if indeed they do not act as irritants and direct excitants to the sebaceous glands or other portions of the skin.

A CASE CLOSELY SIMULATING TRUE PRURIGO.

BY FREDERIC C. CURTIS, M.D., ALBANY.

There is no affection of the skin more characteristic in its constituents than the prurigo of Hebra. I designate the disease by his name, not that it is really necessary, for there is but one prur-

rigo, but because the term, or its adjective, pruriginous, is so frequently used in designating conditions of other and remote diseases which may chance to be similar to those prominent in this disease. Among dermatologists, no doubt, universal exactness has reached such a point that the term prurigo is entirely reserved for the well-known disease so constantly met with in the Vienna clinics to which it was first applied. But writers even of recent time fail to draw clearly the distinguishing characteristics constituting it a *sui generis* disease, and there are many readers of this journal to whom this limitation of nomenclature and the features of this disease, almost never met with in this country, are not familiar. Prurigo is a disease which appears at an early age, usually lasts through life, begins with the gradual formation of small, slightly raised solid elevations, hardly appreciable save to the touch, of a pale red color, affecting especially the extensor surfaces, but finally covering the limbs and trunk, attended with intense and constant itching, so violent that the skin or at least the top of the papules is torn, a small amount of bloody serum oozing and drying to a crust of blood, the skin after a time becoming thickened and harsh to the touch in a way characteristic of the disease, the inguinal glands enlarging to a considerable size, and the skin becoming pigmented as a result of the long-continued effort to relieve the itch. With this array of symptoms, always present, the disease is one that is clearly defined, and evidently there can seldom arise a question as to its recognition.

A case that should so closely simulate this as to be with difficulty distinguished from it, is next in interest to one of the disease itself. Such cases have been occasionally noted. Scattered cases of prurigo are undoubtedly seen in this country, but they are extremely rare. Writers speak of meeting it, but the accuracy of their observation is doubted by most. I know of but two accepted cases that have been recorded, that of Dr. Wigglesworth, reported in 1872, and one by Dr. Campbell, which was presented to the readers of this journal in 1879. The following case had the appearance and history of prurigo to a marked degree when coming under observation, only developing excluding symptoms after observation and treatment. Aside from this the case has interest in itself :

Arthur M., aged 18, the son of a farmer, and American by descent, residing at Stillwater, came under my observation in December, 1881. His parents are healthy and his family history is

clear. He has brothers and sisters, one of whom—two years younger—is said to have a general eruption, but not resembling this, as described, in any respect. In infancy he had seborrhœa, or possibly, eczema of the scalp. At the age of 5 his present disease made its appearance. It began on the legs and wrists, spreading thence year by year over the body, and he has never been free from it since it started. He is better of it in summer, and is then able to work and go to school, but as cold weather comes he is much worse, so that from loss of sleep on account of the intense and constant itching he can do but little. His general health is, however, fair. He has never had systematic treatment.

At the present time he is a fairly well-nourished and developed boy, of about 135 pounds' weight. He has a hopeless, worn expression of patient endurance. His skin is somewhat pigmented uniformly, the face as well being affected. It is also thick, hard, and unpliant, this being most marked on the front of the legs and thighs; to a less degree on the lower part of the abdomen, the front of the arms, the neck, and cheeks; and a little only on the upper part of the trunk and inner side of the arms. The folds of the joints are little affected, except of the knee, where it is considerable. The lines and furrows of the skin are deep, especially, as on the shoulders, where the thickening is at a minimum. The surface here, too, is furfuraceous. Over the thickened parts it is slightly scaly, and at some points there are a few small and thin yellowish crusts. There is little evidence of discharge. On the lower extremities, especially on the calf of the legs and back of thighs, buttocks, and around the lower part of the trunk especially in front, on the arms and forearms, there are scattered, flat, reddish papules, small split-pea size, but slightly elevated above the surface. Many of these have the tops torn and are covered with small blood crusts, which latter, however, are not confined to these, but are to be seen chiefly on the legs, where the skin is torn, having a linear disposition. There is not much of this, however, nor of other crusts, on the trunk and extremities, and the skin is hard and board-like, rough and harsh over these surfaces. The glands of the inguinal region are very considerably enlarged, perfect "prurigo buboes." The glands of the axillæ and neck are also enlarged to a less degree. The thickened, hard, harsh papular condition, as described, is found over the lower limbs and a little up on the trunk, and on a good part of the upper limbs, and somewhat about the neck. The back of the hands and wrists, the face, and the upper half of the trunk, including most of the back, differ. The first region has a good deal of thickening, more epidermal in character, cracked over the flexures, oozing and dirty-looking, being also somewhat crusted. The cheeks, temples, and forehead above the eyebrows have a decided red eczematous condition, and there is some crusting. The nose, and to either side, is dry, red, and slightly scaly. The scalp is not affected. The back and upper trunk is dry, scaling, with deep

furrows; there is little or no thickening. This is most marked between and over the shoulder-blades and along the side of the trunk. The feet are not affected. The only subjective symptom is itching of a most atrocious sort. It is most severe on the parts that are thickened and papular. While about the diverting things of the day it is not so bad, but at night it is so violent as to prevent sleep. Scratching is resisted as much as possible, experience having taught its inutility. The functions of the body were fairly well carried on.

He was sent to the Albany Hospital and put on the daily use of alkaline baths, containing one-eighth pound each of potash, soda, borax, and starch, his body being soaked in this for half an hour. After it he was lavishly covered, and this was done twice a day, with linseed oil containing a drachm of carbolic acid to the quart, a woolen under-suit being worn next the skin without discomfort, and he was kept in a warm part of the ward constantly. Various antipruritic ointments were from time to time given him, to be used *pro re nata*, and likewise gelsemium, opium and chloral were administered at night. Acetate of potash, iron, cod-liver oil, and arsenic in varying doses were given; the latter being employed in the form of the homœopathic powder in which one grain represents one hundredth of a grain of arsenic, and this was pushed to tolerance by increasing and then decreasing doses. He remained in the hospital about five months. After a time the thickening began to yield, though it persisted to a considerable degree, when he was discharged, on the extremities. The eczema disappeared entirely on the face, hands, and arms, and the trunk returned to a very fair condition. The itching was in a large degree relieved, and the papules disappeared considerably. On discontinuing the baths for a time, a few weeks after his entrance to the hospital, the deep furrows and adherent scales noticeable about the upper trunk at first became more marked, and it grew evident that ichthyosis was a feature of the disease. At the time of his discharge this, together with what remained of the thickening and papulation along the front of the lower extremities and forearms which was still itchy but endurable, constituted his condition. He was sent home as soon as warm weather came with the hope that the usual summer benefit might continue the improvement in his condition; I have not heard to what degree that hope was reached.

It appears to have developed as a result of treatment that this case was one primarily of ichthyosis, and it is evident that chronic, universal eczema constituted the rest of his malady. Dr. Bulkley and Dr. Sherwell, to whom I showed this case in February, during the State Society meeting, both agreed in this view. I should have stated before that the sister, already alluded to, I after a time saw and found to have ichthyosis. Had not this

disease come to the surface, and there is no reason why eczema should develop in its connection, I think no one could say that this case was not one of true prurigo, considering its history, lesions, and symptoms. Prurigo in this country may depart from the Vienna type, just as most other diseases do, and it is yet possible that what was clearly eczema here was secondary to prurigo, and that this was the pathology of the case.

A CASE OF FEIGNED ERUPTION.

By H. W. STELWAGON, M.D., PHILADELPHIA.

The dearth of published cases of fictitious eruptions would lead one to infer that they are extremely rare. During the past few years, however, reports of several cases have appeared in the current medical literature, and attention having thus been directed to the possibility of such eruptions, it is probable that future observation will disclose the fact that this class of affections is by no means a small one. These cases probably fall under the notice of the general practitioner or neurologist, from the fact that the skin manifestation is completely obscured by symptoms of seemingly grave constitutional disorder, and the eruption thereby escapes attentive observation. In other words hysterical patients, in whom these feigned eruptions are generally observed, only accidentally reach the dermatologist.

The following curious case came under my observation a few months ago at the Philadelphia Dispensary for Skin Diseases :

The patient, a female, aged nineteen, was brought to the dispensary in regard to an eruption which had persisted almost uninterruptedly for several months. The extent, character, and configuration of the lesions were as follows :

On the anterior aspect of the left forearm were two parallel elongated crusted patches about three inches in length, one third in width, and one quarter inch apart. The crust was thin, dry, dark reddish-brown, closely adherent with the edges slightly everted, and, excepting a slightly-marked inflammatory border, made up the whole of the patch. In general appearance it looked very much like the soiled "stuck-on" crust of impetigo contagiosa, except that it was, of course, darker. On the extensor surface of the same forearm were two similar parallel patches, only differing from the former in being shorter and having a softer crust. In the groove of the elbow was a small abraded eczematous-looking spot. The other forearm, on its anterior

surface, presented the same condition as its fellow, *i. e.*, two parallel patches of the same length and character. The crusts, however, were much softer, and lighter in color, and the border more inflammatory, showing that the lesions here were more recent. The dorsal surface was free.

The tibial surface of both legs showed the same peculiar parallel-crusts patches, shorter but in other respects similar. These were evidently less recent than the others, as in places the wafer-like crust had fallen off; the underlying skin was healed, but somewhat reddish. In the left instep was an erythematous spot showing the site of an old patch. This constituted the whole extent of the eruption. Other patches had existed, but had disappeared. The regions described, however, were the only parts on which lesions had ever appeared. After the nature of the trouble became known the genital region was suspected, but was found entirely free. The lesions were all superficial. The patient was pale, nervous, and was suffering with loss of voice. The past history and existing general condition of the girl showed unmistakable hysteria. According to the statement of the woman accompanying the girl, and with whom the patient lived, the case had been treated at several dispensaries, at various times, but with only temporary improvement. The eruption would seemingly improve while under treatment, but would reappear as soon as medical attention was withdrawn. The eruption had mostly been in parallels. The character and behavior of the lesion pointed decidedly to its artificial production. This supposition was strongly confirmed by the existing hysterical condition. The nails were suspected but were so closely bitten off that they were really harmless. After having the case under consideration for several days the confidence of the patient was won, and upon accusing her bluntly of the true nature of her trouble, and assuring her that the fact would not be disclosed, she confessed. The lesions were produced by constant rubbing with the finger ends—by the forefinger and middle finger. But little force was used, and the rubbing was slow, but was kept up for an hour or more. She stated that the operation was not painful, but, on the contrary, the sensation was to her an agreeable one. Her object was not so much to create sympathy as to obtain the pleasant sensation the rubbing gave her; besides, the impulse to rub was at times almost irresistible. The result was a slight dermatitis, and, in consequence, the crusted lesions described above.

A CASE OF CONGENITAL ABNORMALITY IN THE HAIR-PRODUCTION ON THE SCALP.*

BY DR. GEORGE THIN, LONDON, ENG.

Maria Style, aged four years, is a flabby round-faced child, and squints. She is the second of five children, four of whom are

* Transactions International Medical Congress, London, 1881.

alive. The father is healthy ; but the mother has been completely bald from birth, and has marks of old keratitis in the right eye. The father is said to have an unusually stiff beard. The hair in the other children is natural. When this child was about five or six months old, her mother began to notice that the hair came off when the head was being washed. At present her head is covered with short, dry hairs, which come out easily and freely when subjected to slight traction. The number of hairs growing on the scalp is normal. On the back of the head, forward as far as the ears, and on the back part of the vertex, the hairs measure from a sixteenth to a quarter of an inch long. The longest hairs are on the fore part of the vertex, where the longest are nearly three inches long. Toward the forehead they become shorter, being about an inch long, and less. All over the head the hairs are hard and rough to the touch, the scalp feeling like a pig's skin. The rest of the skin of the body is natural, except that the genitals frequently become tender. The hairs, when examined under the microscope, are seen, many but not all of them, to be varicose in outline, being distinguished by alternate swellings and constrictions, such as are to be found in various abnormal conditions connected with the growth of the hair. I regard the case as an example of congenital deficiency in the cells of the hair papilla, which do not form epithelial cells capable of being knit into a hair shaft of the usual length.

In the discussion which followed, Professor Kaposi, of Vienna, said he had seen two such cases, which, he believed, were referred to as lichen pilaris in his last work on skin diseases. He found improvement followed on treatment by soap, and the application of sulphur and tar paste.

Dr. Vidal, of Paris, had also seen two cases in children, aged four and ten years respectively. The affection seemed to be congenital. The scalp was very dry, the sebaceous system appearing ill-developed, and, may be, atrophied. He found atrophy of the sebaceous gland in an adult suffering from seborrhœa sicca, whose hair, especially over the temples, was broken and twisted in a similar manner.

Dr. Unna, of Hamburg, had met with the same affection in a young lady, but limited to the vertex. In her case it came on after nervous shock (grief), and somewhat resembled alopecia, but there was great dryness of the skin, with a coarse wiry condition of the hair, and the scalp was decidedly indurated. He thought it had some resemblance to scleroderma circumscripta ; great improvement took place under sulphur ointment.

Dr. Liveing, of London, had seen one case similar to Dr. Thin's. The affection had existed from earliest infancy.

Dr. Bulkley, of New York, had seen an exactly similar case in a boy, aged about six years, which had lasted since earliest infancy. The body presented a characteristic lichen pilaris, and upon the arms the hairs were all surrounded by pointed epidermal accumulations, the same occurring to a very slight degree about the hairs of the scalp where they existed, although they were very scant and brittle. The disease in the hairs in this case appeared to be quite akin to the abnormal epidermic growth found in lichen pilaris.

Dr. Thin, of London, in reply, remarked that he did not consider his case as similar to those which had been observed by Dr. Walter Smith and Dr. Liveing. Varicose hairs occur in various conditions, and would seem to imply intermitting energy in the growth of the hair. Their occurrence is not sufficient for the identification of a specific affection of the hair.

CLASS	I.	Morbi cutis parasitici.	Parasitic Affections.
"	II.	Morbi glandularum cutis.	Glandular Affections.
"	III.	Neuroses.	Neurotic Affections.
"	IV.	Exsudationes.	Exudative or Inflammatory Affections.
"	V.	Hæmorrhagiæ.	Hæmorrhagic Affections.
"	VI.	Hypertrophix.	Hypertrophic Affections.
"	VII.	Atrophix.	Atrophic Affections.
"	VIII.	Neoplasmata.	New Formations.

A. VEGETABLE.

1. *Tinea trichophytina* (or trichophytosis) (*parasite—Trichophyton tonsurans*).

{	<i>corporis</i> (or <i>tinea circinata</i>).
	<i>capitis</i> (or <i>tinea tonsurans</i>).
	<i>barbæ</i> (or <i>sycosis parasitica</i>).
	<i>cruris</i> (or <i>eczema marginatum</i>).
2. *Tinea favosa* (or favus) (*parasite—Achorion Schenleinii*).
3. *Tinea versicolor* (or chromophytosis) (*parasite—Microsporon furfur*).

B. ANIMAL.

1. Phthiriasis (or pediculosis)

{	<i>corporis</i>	{	(<i>parasite—Pediculus</i>).
	<i>capitis</i>		
	<i>pubis</i>		
2. Scabies (*parasite—Acarus scabiei*).

A. DISEASES OF THE SEBACEOUS GLANDS.	I. Due to faulty secretion or excretion of sebaceous matter.	1. Acne sebacea	{ oleosa cerea cornea }	(or seborrhœa).
		2. Acne punctata	{ nigra (or comedo). albida (or milium).	
		3. Acne molluscum (or molluscum sebaceum).		
	II. Due to inflammation of sebaceous glands with surrounding tissue.	4. Acne simplex (or vulgaris).		
		5. Acne indurata. 6. Acne rosacea.		
B. DISEASES OF THE SWEAT- GLANDS.	I. As to quantity of secretion.	1. Hyperidrosis.		
		2. Anidrosis.		
	II. As to quality of secretion.	3. Bromidrosis.		
		4. Chromidrosis.		
	III. With retention of secretion.	5. Dysidrosis.		
		6. Sudamina.		

Class III. Neuroses. Neurotic Affections.

1. Zoster (herpes zoster or zona).
2. Pruritus.
3. Dermatalgia.
4. Hyperæsthesia cutis.
5. Anæsthesia cutis.
6. Dystrophia cutis (or trophic disturbances).

Class IV. Exsudationes. Exudative or Inflammatory Affections.

A. INDUCED BY INFECTION OR CONTAGION.

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| | { | 1. Rubeola (or measles). |
| | | 2. Rôtheln (or German measles). |
| | | 3. Scarlatina. |
| | | 4. Variola. |
| | | 5. Varicella. |
| | | 6. Vaccinia. |
| | | 7. Syphilis. |
| | | 8. Pustula maligna. |
| | | 9. Equinia (or glanders). |
| | | 10. Diphtheritis cutis. |
| | | 11. Erysipelas. |

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| I. Erythematous. | { | 1. Roseola. | { | simplex. |
| | | 2. Erythema | | multiforme. |
| | | 3. Urticaria. | | nodosum. |

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| II. Papular. | { | 4. Lichen | { | simplex. |
| | | 5. Prurigo. | | planus. |
| | | | | ruber. |
| | | | | scrofulosus. |

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|-----------------|---|-----------|---|---------------|
| III. Vesicular. | { | 6. Herpes | { | febrilis. |
| | | | | iris. |
| | | | | progenitalis. |
| | | | | gestationis. |

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| IV. Bullous. | { | 7. Hydroa. | { | |
| | | 8. Pemphigus | | vulgaris. |
| | | 9. Pompholix | | foliaceus. |
| | | (or cheiro-pompholix). | | |

B. OF INTERNAL OR LOCAL ORIGIN.

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| V. Pustular. | { | 10. Sycosis (or folliculitis pilorum). |
| | | 11. Impetigo. |
| | | 12. Impetigo contagiosa. |
| | | 13. Ecthyma. |

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| VI. Multiform, <i>i. e.</i> ,
erythematous,
papular, ves-
icular, pustu-
lar, etc. | { | 14. Eczema. | { | |
| | | 15. Dermatitis | | calorica. |
| | | | | venenata. |
| | | | | traumatica. |
| | | | | medicamentosa. |

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| VII. Squamous. | { | 16. Dermatitis exfoliativa
(or pityriasis rubra). |
| | | 17. Psoriasis. |
| | | 18. Pityriasis capitis. |

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| VIII. Phlegmonous. | { | 19. Furunculus (furunculosis). |
| | | 20. Anthrax. |

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| IX. Ulcerative. | { | 21. Onychia. | { | |
| | | 22. Ulcus | | simplex. |
| | | | | venereum. |

Class V. Hæmorrhagiæ. Hæmorrhagic Affections.

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| 1. Purpura | { | simplex.
papulosa.
rheumatica (or peliosis rheumatica).
hæmorrhagica. |
| 2. Hæmatidrosis (or bloody sweat). | | |
| 3. Scorbutus. | | |

Class VI. Hypertrophie. Hypertrophic Affections.

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| A. OF PIGMENT. | { | 1. Lentigo.
2. Chloasma.
3. Melanoderma. | 4. Nævus pigmentosus.
5. Morbus Addisonii. |
| B. OF EPIDERMIS AND PAPILLÆ. | { | 1. Keratosis pilaris (or lichen pilaris).
2. Ichthyosis.
3. Cornu cutaneum.
4. Clavus.
5. Tylosis (or callositas). | 6. Verruca { vulgaris.
senilis.
acuminata.
necrogenica |
| C. OF CONNECTIVE TISSUE. | { | 1. Scleroderma.
2. Sclerema neonatorum.
3. Morphœa. | 4. Elephantiasis (Arabum).
5. Dermatolysis.
6. Frambœsia (or yaws). |
| D. OF HAIR. | | 1. Hirsuties. | 2. Nævus pilosus. |
| E. OF NAIL. | | 1. Onychogryphosis. | 2. Onychauxis. |

Class VII. Atrophie. Atrophic Affections.

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| A. OF PIGMENT. | { | 1. Albinismus.
2. Leucoderma (or vitiligo).
3. Canities. |
| B. OF CORIUM. | { | 1. Atrophia cutis { propria.
linearis (or striæ atrophicæ).
maculosa (or maculæ atrophicæ).
2. Atrophia senilis. |
| C. OF HAIR. | { | 1. Alopecia.
2. Alopecia areata.
3. Trichorexis nodosa (atrophia pilorum propria, or fragilitas crinium). |
| D. OF NAIL. | | Onychatrophia. |

Class VIII. Neoplasmata. New Formations.

I. BENIGN NEW FORMATIONS.

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|---------------------------|---|---|
| A. OF CONNECTIVE TISSUE. | { | 1. Keloid.
2. Fibroma (or molluscum fibrosum).
3. Xanthoma (xanthelasma or vitiligoidea). |
| B. OF GRANULATION TISSUE. | { | 1. Lupus { vulgaris.
erythematosus.
2. Scrofuloderma.
3. Rhinoscleroma. |
| C. OF BLOOD-VESSELS. | { | 1. Nævus vasculosus.
2. Angioma (or telangiectasis). |
| D. OF LYMPHATICS. | { | 1. Lymphadenoma cutis.
2. Lymphangioma cutis. |
| E. OF NERVES. | | Neuroma cutis. |

II. MALIGNANT NEW FORMATIONS.

- | | | | |
|-----------------|---|--|---|
| 1. Lepra | { | tuberosa
maculosa | { (leprosy, or elephantiasis Græcorum). |
| 2. Carcinoma. | | | |
| 3. Epithelioma. | | | |
| 4. Sarcoma | { | idiopathicum.
pigmentosum (or melanosis). | |

I.

DISEASES OF THE SKIN.

GENERAL TOPICS AND THERAPEUTICS.

T. COLCOTT FOX, B.A., CANTAB., M.B., LOND.

Two cases of skin eruption following the internal use of iodoform.—ZEISSL reports the following cases : 1.—A boy, æt. 3 years, had some disease about the lower third of right tibia ; this was laid open for the second time on March 21st, when a sequestrum was removed and the wound washed out with thymol and dressed with iodoform. On the 5th of April there was fever, and a diffuse bright-red rash, fading on pressure, appeared on the trunk and flexor surfaces of both upper extremities and inner surfaces of both thighs. There was no sore throat. The iodoform was left off ; the fever subsided by the third day, and on the 12th of April nothing remained. The urine gave the iodine reaction and was albuminous, with a few renal casts. The albuminuria ceased with the rash. The iodoform was again used on May 13th ; on the 15th the fever, rash, albuminuria, and iodine reaction of urine returned. All these subsided in five days. The boy *gradually got used* to the iodoform dressing and went home well on July 17th.

2.—A male, æt. 36, came under observation July 18th, with phthisis, right psoas abscess, and caries of front of left fourth rib. About the caries of rib were three sinuses which were laid open and dressed with carbolic acid. There was an attack of erysipelas, lasting from July 27th to 31st, in the neighborhood of the disease. On August 2d iodoform was first used. On August 11th there was severe itching of the trunk and extremities, and on the 13th lumps of urticaria and red patches projecting above the level of the skin, sharply circumscribed, from the size of a lentil to that of a kreuzer (one cent piece), with encircling rings of red, healthy skin. The wheals were two centimetres in diameter. The red areas (fading on pressure) existed chiefly on the flexor, but there were some on the extensor surfaces. There were more on the upper than lower extremities, where they existed on both thighs. The skin of the back showed a widely spread erythema and raised places about the width of the palm of the hand. There was no fever, no albuminuria, but there was iodine reaction of the urine. The rash disappeared in seven days.—*Allgem. Wien. med. Ztg.* 1881, xxvi, p. 455.

Electricity in skin diseases.—The following cases are reported by E. KURZ, of Florence. 1.—A young man suffered from a severe attack of urticaria with febrile excitement, after eating shell

fish, with wheals about the size of a thaler. Carbolic lotion alone afforded some relief from the intense itching.

Electricity was used for five minutes to the right arm ; the rapidly interrupted current of 20 cells' strength being alternated with the Voltaic current, the electrodes being frequently altered in position. The irritation and swelling went away at the end of five minutes, leaving only a little redness. The same evening there was an outbreak of urticaria over the whole body, but the following morning the galvanized arm was free from eruption.

Faradization cured the patient except for slight relapse three days later.

2.—A lady was affected with severe herpes intercostalis, and the interrupted current from 10 cells was applied to the groups of vesicles, alternated with frequent Voltaic currents. The treatment was seemingly painful, but the patient had four hours complete ease after it. New vesicles appeared on the following days. The battery (20 cells) was again used as much as possible on the sound skin for a quarter of an hour, the anode being placed on the painful place in the axillary line. This treatment gave complete relief from the pain.—*Deutsche med. Wochenschr.*, Berlin, 1881, vii, p. 451.

On the green color of the hair acquired by old workers in copper.—Authors (Bouchardat, Posner) are quoted as proving the existence of green hair in copper workers. PÉTRI found no green hair in twenty men working in a factory at Cassel. Pétri knew a man, aged 68, who had green hair and discolored gums and teeth, from whom some hairs from the forehead (12 cm. long), and another tuft from the beard (5 cm. long) under the jaw were obtained. On the forehead the copper particles in the man's environment would be able to settle ; not so in the hair from under the jaw. In the hairs from scalp the points showed a gray-green color quite intense for 3 cm., but further from the tips the color gradually disappeared, till at 10 cm. there was only a gray color. The hairs from the beard were of a gray-white color.

The green hairs, if washed in water and wiped along so that the outside of the hair was cleaned, parted with their copper to the washing water, and the microscope showed the absence, as it formerly did the presence, of the crystals, etc., of copper salts. The ordinary ammonia blue color test for copper was got from the hair and from the water in which the hair had been cleaned.

When the man, whose hair was examined, left off work, the discoloration of the hair, gums, etc., quite disappeared. This, however, proves nothing, Pétri says. From what has been mentioned it will be gathered that Pétri holds that the green coloration is merely the result of deposition from the outside and not of secretion from sweat or other structures after absorption by whatever avenue into the body.—*Berlin. klin. Wochenschr.*, 1881, xviii, p. 762.

Naphthol as a new remedy in skin diseases.—KAPOSI reports favorably on the use of the above remedy in skin diseases. One kind of naphthol (B.—naphthol melts at 122° , boils at 290°) is used, having the chemical formula $C_{10}H_8O$, dissolving in an equal weight of alcohol, very little in water, but readily in spirit and water; soluble in oil and fixed fats. Therapeutically, it has been used as a solution in water and spirit, and as an ointment. The smell is scarcely noticeable in this solution and ointment. In thin strata these preparations are colorless; they get red from long contact with air; further they do not stain the hair or skin; nor are the linen or dressings discolored (but this advantage is not absolute). The solution and ointment have been used of various strengths: from 10 to $\frac{1}{2}$ grm. of naphthol in 100 of spirit and water; from 15 to 1 grm. of naphthol in 100 of ointment. An ung. naph. co. was also tried according to the following formula: \mathcal{R} . Naphthol, 15; axung., 100; sapo vir., 50; crctæ. alb. pre., 10; \mathcal{M} .

The preparations have been used in scabies, 52 cases; eczema, 21; psoriasis, 17; prurigo, 6; ichthyosis, 2; pityriasis versicolor, 4; lupus vulgaris, 1; lupus erythematosus, 1; epithelioma, 1; seborrhœa capill., 1; in all 106 cases.

In scabies the compound ointment has been found to be very efficacious, not only in destroying the insects with their furrows, but in healing the eruptions so frequently going with the itch; the ointment was rubbed in thoroughly twice in twenty-four hours.

In psoriasis the remedy has been used with good effect. In three female cases after from 16 to 20 applications in from 8 to 10 days the areas of psoriasis looked so white that they stood out, contrasting with the healthy skin, giving rise to the appearance presented by vitiligo. The result is only to be compared with that from chrysarobin. With the naphthol there was not the smallest discoloration of the sound skin. Any eczema or pustules that were present were straightway healed.

In a case where arsenic was given internally and naphthol was applied to the left extremities, these were well in three weeks, the rest of the body remaining unchanged.

In eczema there is the difficulty of saying when the naphthol should be used. It was found necessary to dilute the drug even as low as $\frac{1}{4}$ per cent., though it was first used as strong as 5 per cent. \mathcal{R} . Water and spirit, 100; naphthol, 5; glycerine, 5. \mathcal{M} . It was found useful in papular and squamous forms. Danger may follow its use in strong preparations and when the skin is not fit, as it gets absorbed. It was very useful in cases with chronic thickening. It may be used where tar could be, and is much better than the latter.

It was useful in seborrhœa.

In prurigo the ointment, without baths or soap ablution, was made of 10 per cent.

In all cases the itching was relieved and the eczematous and pustular eruptions healed.

The drug improved ichthyosis. Lupus erythematosus about nose and cheeks treated with an improvised paste of starch and five per cent. of naphthol applied twice daily for three days, resulted in the formation of a parchment-like, gold-brown, firm scab which separated, leaving the lupus healed.

Lupus vulgaris and epithelioma were not benefited by the application of naphthol.

Naphthol, like tar, is absorbed and separated by the kidneys and alimentary canal. It is also certain that if given internally it can be separated by the skin, and so act on the papillary vessels and nerves. It has been detected in the urine, and imparts a cloudy appearance with change of color, olive green in most cases.—*Wien. med. Wochenschr.*, 1881, xxxi, pp. 617, 641, 681.

Boracic acid as an antiseptic in skin diseases.—The well-known London pharmacutists, Messrs. SAVORY and MOORE, have re-examined the current modes of preparing boracic acid ointment, which varies much in homogeneity and value. Their chemist now recommends that boracic acid should be dissolved in glycerine, and this solution incorporated with fatty bases of white wax and almond oil (not vaseline) to produce a soft, homogeneous, cream-like compound free from all the usual sharp-edged, irritating crystalline plates of boracic acid, which are so hard to reduce to an impalpable powder.—*Practitioner*, London, 1881, xxvii, p. 401.

Iodoform in skin diseases other than those due to syphilis.—FRAZER has found that iodoform compounded with vaseline or lard checks the excessive secretion of some inflammations and removes their purulent character; he also finds it useful in ringworm after the application of vesicating collodion. SQUIRE finds it an efficient application to *moist purifluent surfaces*, for it induces a rapid involution of the suppurating stage of "confluent impetigo." He prefers it as a glycerole. CROCKER agrees in this and finds it of use in some subacute eczemas, mainly of the backs of the hands and forearms. It should not be continued long, and the case must be carefully selected on account of the stimulating properties of iodoform. RICKMAN GODLEE recommends the following formula for applying to lupus after erosion: \mathcal{R} . Iodoformi, gr. x; olei eucalypti 3 ss—3 i; vaseline, ad $\frac{3}{4}$ i. \mathcal{M} .—*Brit. Med. Journ.*, 1881, i, pp. 767, 847, 881; ii, p. 80. *Med. Bulletin*, Phila., 1881, iii, p. 177.

Gynocardic acid and chaulmoogra oil.—WYNDHAM COTTLE has tried chaulmoogra oil and its active principle, gynocardic acid, side by side, and finds that the latter possesses several advantages in that it can be easily given in pills, and so the difficulty of administering large quantities of the nauseous oil, which is hardly got over by using perles, is obviated. The acid, like the oil, improves the nutrition, and patients gain weight, hence it is good whenever there is malnutrition, as in gout and rheumatism,

late syphilis, etc. Locally both are demulcent and lubricant. Cottle has found the acid useful also when administered internally in leprosy (one case) and psoriasis. He commences with half grain doses of the acid with extract of gentian, hops, or conserve of roses several times a day, and has exhibited three grains daily for four months. Locally in eczema the following is a very useful ointment: \mathcal{R} . Acidi gynocard. gr. xv–xxv; vaseline $\frac{3}{4}$ i. \mathcal{M} .—*Brit. Med. Journ.*, London, 1881, i, p. 999.

Remarkable periodical desquamation.—PRESTON, in New Zealand, has observed that a married woman with a large family, who enjoys good health otherwise, has completely shed her skin like a snake at intervals of a month or six weeks since childhood. None of her children have inherited the peculiarity. She suffers from slight malaise for a day or two, and then the skin peels off, forming large casts, from the hands, feet, nose, and ears.—*Lancet*, Lond., 1881, ii, p. 703.

The diagnosis of skin diseases.—MCCALL ANDERSON has published two very interesting lectures with this title, the first devoted to the definition, discussion, and illustration of the primary and secondary lesions of the skin, and the second to their classification. He has adopted a modification of the late Dr. A. B. Buchanan's scheme (*Edin. Med. Journ.*, Jan., 1863). In this it is attempted to arrange diseases usefully from a clinical point of view in accordance with their nature and cause, and both the etiological and pathological principles are involved. The arrangement is as follows:

A. FUNCTIONAL AFFECTIONS OF THE SKIN.	{	I. Pruritus.	{	1. Defective pigmentation.	
		II. Atrophia cutis.		2. Excessive pigmentation.	
		III. Anomalies of pigmentation.			
B. ORGANIC DISEASES OF THE SKIN.	{	I. Those defined by uniform causes.	{	α . Parasitic affections.	
				β . Syphilitic affections.	
		II. Those not defined by uniform causes and comprising all diseases not included in foregoing groups.		γ . Strumous affections.	
				δ . Eruptive fevers.	
				ϵ . Inflammations.	
					η . New formations.
					θ . Hemorrhages.

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PARASITIC DISEASES.

I. EDMONDSON ATKINSON.

The fungus of tinea imbricata (Manson).—Dermatologists generally consider this affection a form of ordinary tinea trichophytina, probably identical with eczema marginatum of Hebra, lichen marginatus of Wilson, Burmese ringworm, etc. Manson's views, showing, in his opinion, the incorrectness of these views, have already been presented in the ARCHIVES OF DERMATOLOGY. THIN studied epidermic scales sent directly by Dr. Manson, and found the quantity of fungus to be very great and the mycelium to vary very much in size. The largest branches were about one half broader than the mycelium of ordinary ringworm, but there was a considerable amount not differing from it in size and ap-

pearance. Thin notes the possibility of other fungi than those of ringworm lodging in the scales exposed on the warm, moist human body in hot climates, and obscuring the diagnosis.—*Trans. Path. Soc.*, London, xxxi, 1879-80, p. 339.

Isolation in ringworm cases not necessary.—THIN asserts that the isolation in cases of ringworm in families and schools is entirely unnecessary, and that all danger of contagion may be obviated by the practice of keeping in constant contact with the patch of ringworm some fatty substance, which, while it may not cure the disease, will prevent its spreading to other localities and other individuals, by precluding the escape of the contagious elements of the fungus.—*Lancet*, i, 1882, p. 250.

Herpes circinatus.—In some "Medical notes from Ceylon," STEVENSON attributes the spread of ringworm among troops to the custom of washing of the clothing of affected persons, in the same vessels that are used for the clothing of unaffected persons. Otherwise the danger of contagion is small. He cites some strong evidence in support of his views.—*Edinburgh Med. Jour.*, 1882, No. cccxx, p. 695.

Chrisma as a parasiticide.—In a note to the *Lancet*, CRANE recommends "chrisma," a product of petroleum, as a remedy in tinea trichophytina, scabies, phthiriasis, etc. It acts promptly and efficiently. It should be applied as an ointment.—*Lancet*, ii, 1881, p. 76.

Pityriasis circinata et marginata.—EMILE VIDAL describes a fungus parasite, which he claims to have discovered in this affection, and which he calls *microsporon anomæon* (*microsporon dispar*). Examined with an immersion objective, No. 10, Hartnack, epithelial scales from a patch of pityriasis circinata exhibit spores of a diameter of one micro-millimetre, many even smaller, larger spores being the exception, never exceeding one micro-millimetre in diameter. The principal characters of this fungus are: 1. The diminutive size of the spores, and their great variation in volume. 2. A circular arrangement in the epithelial cell. 3. The scarcity of chains of spores. 4. The absence, or, at least, great rarity of mycelium. The fungus affects the superficial and, particularly, the middle layers of the epidermis. It is to be observed more especially upon the face, beard, and neck. The hair escapes, and its follicle does not become inflamed. The clinical signs of the affection are described, and its differential diagnosis with "pityriasis rosea, pityriasis versicolor, erythrasma, and trichophytosis circinata" indicated. V. has never seen the affection in persons of more than 40 years of age, and has never known it to spread by contagion. Its cure is easily effected by the use of ordinary anti-parasitic remedies.—*Ann. de Derm. et de Syph.* 2s., vol. iii, p. 22.

A peculiar form of dermatomycosis.—H. HEBRA describes a peculiar eczema-like eruption, consisting of papules and vesicles upon a reddened base, patches exuding and covered with scabs, with, here and there, the epidermis stripped off even to the papillary layer. Morbid areas are not sharply circumscribed by healthy parts. The course of the affection is especially chronic, lasting for years, spreading and itching. The locality of the eruption was its most striking feature, it being symmetrically arranged on the throat, both elbows and knees, rarely elsewhere. Hebra declares the constant presence in this affection of fungus elements, shining and of small size, generally heaped into large masses resembling the fungus of tinea versicolor, with which disease, indeed, Hebra sees a possible identity. He treated these cases with unguentum diachyli until all loss of substance was repaired, and then applied Wilkinson's ointment for a week. In recent cases, cure was secured in from 5 to 6 weeks. In old, obstinate cases a 10 per cent. pyrogallic acid salve, and 5 per cent. solution of salicylic acid with starch were employed.—*Wien. med. Blät.*, 1881, IV, pp. 1195-1232; *Viertelj. f. Derm. u. Syph.*, IX, 1882, p. 141.

Histological investigations of favus and tinea trichophytina.—His conclusions from the study of favus and tinea trichophytina are given by BALZER. The elements of the fungus are all derived from the spore. In elongating and developing, it forms a mycelial filament. The nuclei within this bud and segment so as to form a sporiferous tube. New spores are formed by the segmentation of the mycelial sheath. Sometimes the spores are only formed at the extremity of the filament; sometimes whole filaments are transformed into chains of spores. Dermatophytes may follow three different courses: 1. They may indefinitely increase when they find the conditions favorable to their growth. 2. After having invaded a certain portion of the skin, they may remain inert. 3. They may disappear after having completed life histories. The favus cup he considers to consist of the elements of the fungus and great quantities of micrococci. The spores are of varying shape and volume, composed of a homogeneous and transparent envelope and a central substance coloring with reagents. The mycelial tubes are of very irregular form and branch at short intervals, have transparent and homogeneous walls, and enclose irregularly cubical spores. The spores are partly derived from intra-tubular segmentation and partly by simple budding. Alterations of the hair occur only secondarily. When implicated it is of brittle, grayish, shreddy aspect. Balzer agrees with those who hold that the achorion invades the true skin. He observes three phases in the evolution of favus: 1. The phase of intra-epidermic vegetation. 2. The phase of intra-dermic vegetation. 3. The phase of cicatrization with alopecia. The elements of tinea trichophytina differ from those of favus in the length, thinness, regularity, and scanty ramification of the my-

celium, the smaller volume and the elliptic or oval shape of the spores. There are also differences due to location, the achorion being most at home in the soft portions of the epidermis, the trichophyton in the dry, horny layers. The epidermic scales contain chiefly mycelia, while the hairs have spores mostly. The trichophytic elements invade first the peripheral portions of the hair, later the medulla.—*Arch. gén. de méd.*, 1881, ii, p. 385; *Ann. de Derm. et de Syph.*, 2 s., iii, p. 53.

On filaria sanguinis hominis in South Formosa.—Formosa is an island 180 miles wide, and in constant communication with Amoy (where, according to Manson, one in ten of the inhabitants, have filaria in their blood), and yet, according to MYERS, one finds filaria infection only very rarely. The only three cases he saw were immigrants from the mainland. This immunity is attributed to the absence from the island of the suitable species of the mosquito to act as the intermediate host. Myers' results bear out Manson's statements as to the hours during which filaria may be detected in the blood. He thinks each appearance of the embryo filariæ is a new brood which perishes forthwith. In reply to the objection that, if the filariæ die in the blood within twenty-four hours, why do they live longer when liberated? the author claims that the withdrawal from the blood is a compliance with the natural requirements of the parasite, failing to effect which, it dies.—*China Imp. Customs Med. Rep.*, 1881, xxi, p. 1; *London Med. Rec.*, 1882, No. 79, p. 3.

On filaria of the blood and its relations with elephantiasis Arabum and some other affections of hot countries.—A general review of the questions involved in the discussion of this subject is presented by BARTH, together with its complete history to the date of writing.—*Ann. de Dermatol. et de Syphil.*, 1881, 2 s., ii, pp. 546-677.

Lymph-scrotum.—MANSON reviews the history of filaria of lymph-scrotum, the parent of the embryo nematode discovered by Wucherer in 1872, and called by him filaria sanguinis hominis. This (the parent) was first discovered by Bancroft in 1876, and by Lewis in 1877. More recently, others have detected it. It was named by Cobbold, filaria Bancrofti, in honor of its discoverer. The male is considerably smaller than the female. The latter is long, slender, hair-like, quite three inches in length by $\frac{1}{100}$ inch in breadth, and contains a narrow alimentary canal and reproductive organs. The vagina is a short and bifurcated course, and opens $\frac{1}{25}$ from the head. It divides into two internal horns, which, stuffed with the embryos in all stages of development, run nearly to the tail. The creature is therefore viviparous. The parent, lying in a lymphatic vessel, emits the young into the lymph stream, through which it finally meets the blood. Here, as well as in the lymph, this embryo, under a high power of the microscope, is seen to be a long, slender, snake-like creature,

so active that, when living, its characters can hardly be distinguished. It measures from $\frac{1}{90}$ to $\frac{1}{3500}$ inch, is perfectly transparent and apparently structureless, tapering at either end. This embryo is not to be detected at all times in its host. During the day it is absent, but begins to appear about six or seven o'clock in the evening, and its numbers rapidly increase until about midnight, when as many as a hundred individuals may be counted in a single drop of blood. Gradually the numbers diminish from this hour until eight or nine o'clock A.M., when none can be found. This routine is observed month after month. Manson concludes that these embryos undergo no further development in the human body. In searching for another host for the further development of the parasite, he asserts that he has discovered it in the mosquito, or, rather, in a special variety of this insect, which he describes. Sucked by the female mosquito from the blood of a filarious person, the embryos mostly die and are digested. Some, however, survive and enter upon a peculiar metamorphosis. The body becomes broader and shorter, and filled with a granular fluid. Definite structure is developed. The animal, $\frac{1}{30}$ inch in length, remains in the stomach of the mosquito until the death of the latter, which occurs in from four to five days. Beyond this point its history is obscure. At this time it possesses an alimentary canal and boring apparatus, and is supposed either to find its way back into the human body in drinking water or to penetrate by its own efforts. In 1,000 natives of Southern China, taken indiscriminately, the *filaria sanguinis hominis* will be found in the blood of 100 some time between sunset and sunrise. A considerable number of these persons will enjoy good health; some will have irregular febrile attacks; some, enlarged lymphatics; some, lymph-scrotum; some, elephantiasis of the scrotum or legs, etc. Manson concludes that there is a connection between the filaria and these diseases. The parasite only excites disease by obstructing lymph channels. Other obstructions may produce similar effects. In lymph-scrotum the symptoms are caused by embolic closure of lymph glands by ova.—*Transact. Path. Soc. London*, vol. xxxii, p. 285.

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DISEASES OF THE GLANDS.

W. A. HARDAWAY, M.D.*

Suette miliaire.—JULES ROCHARD relates the following observations made upon an epidemic of this disease which occurred on the island of Oleron during the summer of 1880. There were 142 deaths per thousand cases, and among a population of about 20,000. No such severe epidemic has visited France for 30 years. The following are the characteristics of this disease: Sudden attack, rapid evolution, profuse perspiration, well-defined eruption, epigastric pain, dyspnœa, sometimes pushed to suffocation, constipation, and insomnia. The intense and rapidly fatal course of this disease has been noted by all observers—death occurring in some cases in less than twelve hours,—as well as the length of convalescence and the rapidity with which the cadavers become putrefied. The “suette” crosses distance with astonishing rapidity, and attacks a score or more of persons on the day of its appearance in a village. The temperature, which had been neglected in previous epidemics, has been noted in the present

* I am indebted to Dr. Chas. Biart's assistance for this report.—W. A. H.

one. In mild cases the thermometer fluctuated between 98.6° F. and 100.4° , in more serious ones it rose to 104° and 105.8° , and finally, in two fatal cases, to 108.5° and 109.7° . Ipecac. in about twenty-grain doses at the inception of the disease, together with cold lotions, has given better results than any other medication. The cold lotions especially were used in high temperatures.—*Arch. gén. de méd.*, April, 1881.

Hypodermic injections of nitrate of pilocarpine in bromidrosis of the feet, and the comparative action of pilocarpine and jaborandi.—In his observations on the above, Dr. ARMINGAUD found: 1st. That data as yet are not sufficiently numerous to affirm that pilocarpine is a never-failing remedy in fetid sweating of the feet. 2d. That the action of that drug in intermittent fever is such as to give rise to a certain amount of distrust. 3d. That repeated hypodermic injections of nitrate of pilocarpine seem to have a curative action in bromidrosis of the feet. 4th. That suppression of the perspiration of the feet, obtained by the use of this drug, does not seem to give rise to any serious consequences, even when it occurs brusquely. 5th. That it will require a longer period of observation of his patients to establish the permanence, or otherwise, of this action. 6th. That pilocarpine in this case produces a derivative and substitutive hypersecretion of the salivary glands, and that the sudorific action, which is always more certainly and more completely obtained by jaborandi than by pilocarpine, does not seem capable of being advantageously substituted for the sialogogue action of the last-named drug.

It would be a matter of great interest to ascertain whether the product giving the morbid perspiration of the feet its fetid odor—probably due to its decomposition,—not being excreted any longer through the palmar and lateral surfaces of the toes and the soles of the feet, is not eliminated with the saliva produced in this manner.

It would be necessary, however, to be certain of the odor-giving principle, which we are not. We must, however, have due regard for the opinion of Robin, who, having found leucine in this morbid secretion, attributes the fetor to the decomposition of this substance, and the formation of valerianate of ammonia.—*Gaz. hebdom.*, Feb. 18, 1881, p. 101.

Agaricus in night-sweating.—Dr. R. N. WOLFENDEN'S observations upon this subject, in nearly 40 cases, lead him to consider this drug of value equal to atropia, and even superior to it, from the fact that it is quite innocuous. Ten grains too much or too little produce no toxic effects. Twenty grains are usually sufficient, given at bedtime, though thirty grains may be required to entirely check the sweating. The great quantity of the powder, which is bitter, is the only inconvenience attending the administration of large doses. The only effects that he has ever seen produced by large doses are nausea, which stops on diminishing

the dose ; or diarrhœa, which is obviated by combining it with one or two grains of Dover's powder. His cases were all phthisical, and hence nothing can be said of its effects on sweating from other causes.

He believes it to be a preparation worthy of extensive trial.—*Med. Times and Gaz.*, 1881, ii, p. 442.

Sweat secretion.—In reference to this secretion, Dr. UNNA, of Hamburg, said, that although the parts of the nervous system concerned in its production have been defined by recent physiological research, showing the mutual independence of circulatory and sweat phenomena, yet the old puzzle of "cold sweat" and "dry heat" still remained unsolved. This failure on the part of a one-sided nerve-theory has led Dr. Unna to criticise the opinions held as the basis of the ordinary theories of the sweat secretion. Neither physiology nor pathology have shown that the sweat which exudes from the sweat pores comes exclusively from the sweat-coils ; nor does such conception harmonize with the facts of comparative anatomy. The existence of an unbroken histological series of gradations, between the ordinary sweat-glands, and the glands around the anus, in the axilla, and in the ceruminous glands of the ear, and the fact that the latter continually, and the former intermittingly, pour out a secretion containing mucus, fat, or pigment, have hitherto not been contested. The watery element must partly be drawn from the blood-vessels of the papillary layer, partly, perhaps, from those surrounding the duct, and from the rete mucosum, a free communication existing between the inter-epithelial spaces of the prickle-cell layer and the lumen of the duct. Hence the sweat is a mixed fluid, derived from different sources, its reaction varying according to its composition.

Nerve physiology has only shown that the sweat secretion is independent of blood pressure and of the rapidity of the circulation, but not of the circulation as a whole ; and we must reject the theory which holds that the sweat-coil secretes watery sweat under continual nerve stimulus.

The best theory is that derived from a vaso-motor and a musculo-motor hypothesis ; it explains the action of the involuntary muscles connected with the gland, the transitions between fatty mucoid and pigmented sweat, and especially the phenomena of "cold sweat." The "dry heat," observed chiefly in general febrile states and in certain skin diseases, requires other factors outside of the range of the nervous system for its explanation. Amongst these, the expansion by heat of the horny layer of the epidermis deserves especial attention, as by this means the cleft-shape lumen of the canal in the stratum lucidum is shut. We are thus led to a wider view of the sweat secretion, and to the idea of a division of labor amongst the different sweat-producing organs. The conception is calculated to throw new light on certain skin diseases.—*Transact. Internat. Med. Cong.*, 1881, viii, p. 187.

Bromide rash.—Dr. PERCY BOULTON, of London, reports a case of this kind, in a woman, who entered his service for pelvic pain. After administering tincture opium and quinine for several days, he gave her three grains of bromide of iron three times a day. When about one drachm of bromide of iron had been taken altogether, a few spots suggestive of bromide rash appeared about the face. The bromide was then discontinued, and other remedies given. About two weeks after the administration of the bromide had been withdrawn, the patient's legs were still pretty uniformly covered with a discrete pustular eruption. He was certain from careful examinations that it was not specific, and suspected bromide rash, which looked unlike any thing he had ever seen, except pustular eczema (ecthyma). Dr. Thin being called upon to make a diagnosis, pronounced it a case of bromide rash. He said, that although the diagnosis was at the first glance by no means easy, it was nevertheless possible to make it from the objective character alone. When Dr. Thin first saw the patient, her thighs and legs were thickly studded with papules and pustules—a few were visible on the arms and on the shoulders, the rest of the body being free. The seat of eruption was the unusual one of the anterior surfaces, exclusively, of the lower extremities. The papules became pustules, the latter attaining the size of a large pea; the papules themselves being preceded by a small, hard, subcutaneous swelling. The lesion, then, had three stages: induration, papulation, and suppuration, the last stage presenting the special character of the eruption. The inflammation terminated in a free bullous pustule rarely found in any recognized form of skin disease. Secondary syphilis was excluded on account of the pustule being uncomplicated, and by the localization of the eruption. Further, the eruption made its appearance during the administration of bromide of iron; it disappeared in a few days, without treatment, leaving in the place of the larger pustules dark brown spots, with dry adherent scales in the centre.—*Lancet*, Oct. 15, 1881, p. 663.

Pathology of molluscum contagiosum.—Dr. THIN describes the appearances he has observed in preparations from more than fifteen of these tumors. With one exception, no hairs or sebaceous glands were found in all these preparations. Hence, it followed, that the development of these tumors was attended by falling out of the hairs and disappearance of the sebaceous glands. The formation has no duct, and there was no sebaceous secretion in the cells. The tumor was composed of rounded epidermic masses and not of glandular elements. It was formed by a small number of independent growths, which began on the free surface of the epidermis, close to each other. These coalesced as they grew, and formed one tumor. In one section the primary point of origin was traced to a hair follicle. Dr. Thin, following Virchow, assigned the first abnormal action to the cells of the internal root-sheath. The hair dropped out of the distended

follicle, the sebaceous glands atrophied, the follicle became enormously widened, and new growths bulged out from the epidermic root-sheaths of the hair. The small group of separate, independent points of development, which coalesced to form the tumor, probably originated from being inoculated by molluscum cells, which escaped from the distended follicle. As the morbid process could develop from the free surface of the epidermis, its origin in a follicle might not be invariable. When a molluscum body developed from an epidermic cell, the cell first filled with granules, clear spaces becoming visible in different parts of the cell. These granules enlarged and finally coalesced into a homogeneous mass, the muscles being pushed aside, and finally disappearing. When development was complete, an epidermic shell contained a mass of homogeneous substance, which had special physical and chemical properties. This substance was a new product foreign to the healthy cell. It sometimes fell out, and the epidermic cell-wall remained, retaining its shape and consistence. The molluscum body, therefore, remained an epidermic cell from beginning to end, its natural evolution having been interfered with by an unknown cause acting from without. This morbid agent lodged first in the follicle, and then developed, multiplied, and infected the epidermis in the immediate neighborhood of the follicle.—*Med. Times & Gaz.*, 1881, Jan. 15, p. 89.

Molluscum contagiosum.—Dr. CROCKER showed a series of microscopical specimens of this disease to the Pathological Society of London. They tended to show its origin in the hair follicle, the molluscous change beginning in the cells of the internal root-sheath, gradually advancing to the corneal layer of the skin, and the upper part of the rete Malpighii. In the lower part of the rete there was a gradual transition to granular cells, as described by Dr. Thin.

His observations confirmed those already given by Dr. Thin.—*Brit. Med. Journ.*, Jan. 15, 1881.

Molluscum contagiosum and its affinities.—In his communication to the Pathological Society of London, on observations made upon the above, conjointly with his brother, Alex. Morrison, Dr. B. G. MORRISON says: That, contrary to his opinion expressed at a previous meeting, that the tumors were hypertrophied sebaceous glands, he now thought that other structures besides these might be involved, and expressed his doubts as to the absolute correctness of the glandular theory of their origin. He obtained specimens from the buttocks of a child 3 years old. The 8 or 10 tumors on each buttock presented the characteristics of molluscum contagiosum; the covering of each consisted of epithelium only; the whole body was epithelial, and presented, coarsely, a gland-like structure. They examined the hair follicles and skin of the perinæum near the anus, in an adult, to make comparisons regarding the normal hair follicle and sebaceous glands as continuous structures, and considered in their relation to their de-

velopment. In the skin of the perinæum he found crypts lined with epithelium,—atrophied hair follicles, some of which still retained the atrophied fragment of the hair. Ingrowing processes from the rete mucosum were also to be seen,—hair follicles in process of development. In the external auditory meatus, the sebaceous appendages of the hair follicles were greatly developed ; so that these glands, after shedding of the hair, much resembled the tumors of molluscum. The sebaceous glands were constructed most externally by cells from the rete mucosum, within these by squamous-looking cells, and centrally the cells held sebum, and might give rise to considerable spaces from degenerative destruction. The periplastic material formed a complete reticulum supporting and connecting the several structures. In molluscum contagiosum the epithelial tissue alone was concerned. The peripheral tumor substance was formed of cells like those of the rete mucosum ; a large number were vacuolated, and these last cells formed the “molluscous bodies,” so named by Dr. Tilbury Fox. The vacuolated elements were more spherical and much larger than the others, and their size increased toward the centre of the tumor, which was constituted by irregular distinctly walled spaces holding a homogeneous, hyaline-like material. The periplast peripherally encased the cells, more centrally it increased in amount, and most internally formed distinct fibrous-looking septa, which might in parts disappear after degeneration. The essential pathology of molluscum contagiosum, therefore, he considered an epithelial overgrowth conjoined with sebaceous degeneration. No fungus was discoverable in connection with the growth. The horizontal rete mucosum might be uniformly hypertrophied, but this formed no essential part of the changes ; the disease originated in overgrowth of hair follicles (obsolete or not), or from sebaceous glands, or the crypt-like processes of epithelium, such as occurred in normal skin. From the degeneration of the more central part of the overgrowth resulted the fatty material of the tumor. In this view no special kind of irritation was needed to occasion the disease.—*Brit. Med. Four.*, May 14, 1881, p. 768.

Chromidrosis.—Dr. T. C. Fox read a paper on two cases of this disease, before the Clinical Society of London, in which a deep blue-black pigment exuded upon the skin of the circumorbital region. One case occurred in a girl, æt. 18, partially deaf-mute, intelligent, and of good physique. There was a conspicuous symmetrical black pigmentation of the eyelids and a large portion of the adjoining cheeks. The catamenia appeared first at the age of 15, and had never been regular in time or quantity ; since that time the girl had suffered from general malaise, severe headaches, and very marked habitual constipation. She was not hysterical. The pigmentation was first noticed on the lower lids, whence it gradually spread. Placed under observation, it was found that the pigmentation varied considerably in amount and intensity, but present in some degree pretty continuously. It was always less at the catamenial period, seemed to bear a relation to the very ob-

stinate constipation, and was the more intense and extended the longer the interval between the relief of the bowels. The pigmentation was found to disappear on several occasions on the bowels becoming regular. On examination of the urine, indican was found to increase markedly, *pari passu*, with the constipation, and the exudation of pigment, which presented characters in all respects similar to other cases recorded by Robin, and others. The Indian-ink-looking amorphous granules were insoluble in nearly all reagents, hot or cold, but when moistened with glycerine a deep blue color was displayed, and when dissolved in hot sulphuric acid, a beautiful purple hue was first given, and finally a bistre tint. The pigment was evidently indigogenous.

CASE 2.—Girl, æt. 18, hysterical and phthisical, suffering from flatulent distension and constipation. The pigment offered the same reactions as in the first case, but the pigmentation was slighter and more fitful in appearance.

Pigmentation in both cases was increased by any heat, emotion, etc., determining the blood to the face. Dr. Fox insisted on the reality of the affection, which he challenged any one to disprove. The chief points discussed were the causation, and the relation of the exudation to uterine troubles, general debility, and, especially, constipation; the influence of emotion, heat, etc., in increasing the pigmentation, and the sites it usually occupied; the probability of its being exuded in a soluble form in the sweat rather than sebum, and its subsequent oxidation into a colored pigment by contact with the air; the varying shades of the color in different patients, and in the same patients at different times; the constant chemical and physical characters of the pigment, which are proved to be indigogenous; and to similar products found in urine, pus, vomit, fæces, milk, dropsical fluids, etc. Dr. Fox gave the latest researches into the production of indican in the economy, and its connection with chromidrosis.

Very little hyperæsthesia had been present in his cases. To the thirty-nine collected by Dr. Foot, he added five others; 6 in males and 38 in females, at ages ranging between fifteen and fifty-seven, with a mean age of twenty-two. The removal of the matter was not followed by constitutional effects; there was no evidence of steatorrhœa in the majority of the cases cited. In one case phthisis was suspected. No bacteria were found in the solutions of pigment. He did not agree with Dr. O'Connor that any connection existed between these cases and those of xanthelasma.—*Brit. Med. Jour.*, 1881, i, p. 921.

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(Balance of recent literature reserved for want of space.)

EXUDATIVE OR INFLAMMATORY AFFECTIONS:
ERYTHEMATOUS, PAPULAR, VESICULAR,
BULLOUS, AND PUSTULAR.

H. W. STELWAGON, M.D.

Erythema gyratum perstans in two elder members of

a family.—Under this heading Fox reports two curious cases. The patients were brother and sister, aged respectively nineteen and a half and eighteen. The disease had existed since early childhood, with occasional improvement. The family history was good. The eruption begins by the evolution of scattered, isolated, slightly raised erythematous, millet-seed papules, accompanied by the most intolerable itching. These papules quickly extend centrifugally, whilst the central hyperæmia as rapidly subsides, so that in a few hours after the appearance of the papules, a circular area of skin is observed, pigmented but otherwise normal, ever enlarging in exact ratio with the narrow, slightly raised, advancing erythematous border. Such areas complete their desquamation so rapidly, that there is only a ragged cuticular fringe, adherent to the inner edge of the advancing erythematous border of the ring. This white fringe constitutes a very curious and conspicuous feature. As the rings continue to enlarge, as they may do up to about the size of the palm, they meet other adjoining similar rings and fuse together, and so in time large tracts of skin are covered with festooned and gyrate figures. The skin over which the erythema has travelled in a few days resumes its normal condition, except as regards the pigmentation.

Both patients are subject to recurrent non-febrile outbreaks of greater or less intensity which occur at least every three months and last from ten days to six weeks according to the severity, and then the greater part of the trunk, with the extremities, especially the extensor surfaces, may be attacked. In the intervals between the outbreaks also there is a continual evolution of papules here and there, particularly over the shoulders, thighs, and buttocks. The skin has never been absolutely free since the disease made its first appearance. The palms and soles, face, neck, and scalp, are never attacked, and rarely the dorsal surface of the hands and feet. The disease is less intense in winter. The male patient noticed that the eruption will start from the region of any scratch or cut. The disease seemed but little influenced by treatment. After due consideration and weight of what it might be, Fox concludes that it belongs to the erythemata—a phase of the annular erythema. A chromo-lithograph accompanies the communication.—*Trans. Clin. Soc. London*, 1881, xiv, p. 67.

Cases of erythema or herpes iris.—Several very interesting, and in some respects a few extraordinary cases of this affection are reported by CROCKER. In concluding the communication he adds: "We have, therefore, the following forms of this curious condition, with diversely colored zones.

"1. Those which form one or more rings of vesicles around a central bulla, which either remain as vesicles, or become pustular and then leave scars,—the typical herpes iris.

"2. A succession of concentric zones, the outer one consisting of the cuticle raised by the effused fluid.

"3. Concentric zones of erythema which remain erythema only throughout, which may constitute the whole eruption, or be a part

of a multiform erythema."—*Trans. Clin. Soc. London*, 1881, xiv, p. 133.

Lichen planus.—In a clinical lecture on lichen planus, CROCKER gives the results of his microscopic examination of excised papules of this disease. His investigations are given in detail, and in summing up, he says: "The general conclusions I would draw, therefore, are:

"1. That the process at its commencement is entirely superficial.

"2. That it consists of an inflammatory effusion from the superficial plexus of vessels, the cells in horizontal vessels coming only from the upper wall.

"3. That all the vessels of this plexus are notably dilated, and the papillæ enlarged by down-growth of the interpapillary processes.

"4. That all the epithelial layers undergo proliferation, those in the rete mucosum taking the most prominent part in the formation of the papule.

"5. That the involvement of the hair follicles is not an essential, nor the main feature of the process in most cases; but,

"6. That the sweat ducts have more often an influence in determining the position of the papule."—*Lancet*, London, 1881, p. 77.

Urticaria perstans.—PICK observes that in addition to the form of urticaria described as "chronic urticaria," in which evanescent wheals continue to appear for an indefinite period, there are two forms of the chronic disease which are "stationary" in character. In one of these, wheals and the accompanying hyperæmia are present and persist for some time. In this variety, reddish macules remain visible for some days after the wheals have disappeared, doubtless connected with the hyperæmic injection. This form, Pick observes, is probably the one Willis described as "urticaria perstans." Five such cases have come under Pick's notice, three of which are reported in the communication. In these the patients were aged sixteen, twenty-four, and fifty-three.

In the second of these two forms there is considerable discoloration, which remains a long time after the injection has faded. This form corresponds to the "urticaria pigmentosa" of other writers. Two cases are given. One was in a girl of eight years, in whom it had existed since she was six weeks old; the other was in an infant of seven months, the disease having appeared a few days after birth. In this latter case, a portion of a wheal with the pigmentation was excised and examined microscopically. Little hemorrhages were found in the centre surrounded by small-celled infiltration of the areolar tissue.

In most cases there was observed more or less swelling of the lymphatic glands, leading to the conclusion that disturbances exist in the current of the lymph streams, which render absorption slower. Pick concludes:

"'Chronic urticaria,' then, is that form in which evanescent wheals continue to appear during months or years; 'urticaria

perstans,' where the wheals themselves persist for some length of time; 'urticaria perstans hæmorrhagica,' where to the form just mentioned is added pigmentation.'—*Zeitschrift für Heilkunde*, Prag., Jan., 1881-2, p. 417.

Pemphigus in infants.—HUTCHINSON states that from his experience infantile pemphigus is almost invariably syphilitic. As a rule the disease terminates fatally, and in a very short time. That occasional recovery does take place, he admits, and relates several such instances, in which the syphilitic nature was undoubted. The disease often shows itself in several children in succession, generally appearing during the first week. Mercury is to be given at once.

Hutchinson disagrees with the opinion of Diday, that the pemphigus of syphilitic infants is due rather to the cachexia produced by syphilis than to the syphilis itself, having seen it repeatedly in children who otherwise seemed to be quite well.—*British Med. Journ.*, 1882, i, p. 79.

(Recent literature reserved for want of space.)

NEW FORMATIONS.

GEO. H. TILDEN, M.D.

Multiple fibromata of the skin, and their relation to multiple neuromata.—At the celebration of the twenty-fifth anniversary of the Pathological Institute in Berlin, VON RECKLINGHAUSEN contributed, in honor of the occasion, the detailed reports of two cases of multiple cutaneous fibromata combined with multiple neuromata, together with a very thorough commentary upon the same. The cadaver of a woman, fifty-five years of age, presented cutaneous tumors, countless in number and of various sizes, for the most part spherical in form and pediculated. The larger ones especially were polypus-shaped, and reached a size of five centimetres in length by four centimetres in thickness. These growths were most numerous upon the breast and belly, while upon the back they were of larger size and more thickly crowded together, being in the latter region almost all pediculated and as large as a walnut. There were also many of these tumors upon the back of the head. They were covered with entirely intact and smooth skin, and many of them sent out processes into the subcutaneous tissues, which processes could be easily felt through the attenuated cutis. Some of the tumors were harder to the feel than others, and in the larger ones especially were to be distinguished localized spots of induration. The tissue of which these tumors were composed was whitish in color, and moderately soft, lax, and transparent, often opalescent in appearance. Easily detached from the surrounding subcutaneous tissues, the tumors presented rounded protuberances

which dovetailed into the latter. Many of these growths could be pulled apart, disclosing a looped and twisted net-work of bands of varying diameters. The tissue which occupied the meshes of this net-work, differed from the tissue forming the bands themselves, by its greater laxity and ductility. Those tumors which were confined entirely to the corium were very small in size and not homogeneous, but obscurely plexiform in structure. In both mammary glands were situated dense, white masses of almost homogeneous texture, not separable from the surrounding tissues. On the trunks and branches of the cutaneous nerves, and of the nerves of the extremities, notably upon those of the lower extremities, were found multiple fibromatous neuromata. Soft fibromata of the periosteum of the left tibia and small miliary fibromata in the walls of the stomach and jejunum were also discovered. The patient had stated that the tumors of the skin had existed all her life and had caused her neither pain nor inconvenience, but she was unable to say whether they had increased in size or number.

Upon microscopical examination, the neuromata presented most plainly the characteristics of soft fibromata. There was not the smallest new formation of nerve fibres, and neither fatty degeneration nor disintegration of existing nerve fibres, these being well preserved and traceable through the thickest neuromata. There was evident, however, new (added) formation of connective tissue in long, wavy bundles, very delicately fibrillated, containing small, somewhat flattened, and longish connective-tissue corpuscles, and traversed by a widely meshed net-work of blood-vessels. The contained bundle of nerve fibres was but very slightly dissociated by the newly formed connective tissue, most of which was contained between the bundle of nerve fibres itself and its lamellated sheath.

The fibromata of the skin were made up of a transparent though viscous connective tissue, containing cells of exceedingly small size, so that after staining, only the nuclei of the same were noticeable. These cells were more numerous than in the connective tissue of the normal corium, and the newly formed tissue itself much softer and less distinctly striated. The harder the tissue forming the tumor, the more plainly striated was its structure and the greater the deficiency in blood-vessels. The only elastic connective tissue present was that which served to bind together the bands and lumps of which the tumors were made up, and the filaments which ensheathed the cutaneous glands involved in the new growth. The soft tissue forming the tumors was separated into compartments which contained the more coarsely meshed and more distinctly striated connective tissue of the normal corium. The tongued-shaped protuberances on the under side of the tumors were found to contain, for the most part, altered sweat-glands, sometimes hair follicles, and occasionally an entering nerve. The arteries contained in the new growth were thoroughly embedded therein, but still surrounded by a thin adventitia. The epithelium lining the canals of the sweat glands, on the other hand, was in

immediate contact with the tissue proper of the tumor, without any intervening sheath. As a rule the hair follicles were unchanged, the outer longitudinal fibrous envelope losing itself in the tumor. Sometimes, however, the hair was seen to be torn away from the hair papilla, the bulbous end of the hair being split like a broom. The muscular bundles attached to the hair bulb were parted longitudinally, by the new growth, into isolated bands. The bundles of nerve fibres and the solitary nerve fibres present, were naked, destitute of any connective-tissue sheath. Neither changes in the nerve fibres themselves, nor any separation of the individual fibres composing a bundle, were apparent. The coils of the sweat glands contained in the tumors were more or less unrolled and separated, with, in some instances, decided elongation of the canal, which here and there contained masses and cylinders of hyaline substance. The small nodules in the corium consisted likewise of crumpled bands of finely fibrillated connective tissue, richer in cells than the tissue of the normal corium.

The nodules in the walls of the stomach and intestine were made up of the same soft, cellular connective tissue as the cutaneous tumors. Any connection between them and the nerves of the stomach and intestine was difficult of demonstration, but in two of the nodules in the walls of the stomach were found large, rounded, granular bodies, destitute of nuclei, and regarded by von Recklinghausen as probably ganglion cells of the plexus myogastricus in a condition of atrophy. Besides the above, were found in the mesenterium of the jejunum and on the stomach small neuromata situated upon nerve filaments. The growths in the periosteum of the tibia proved to be very soft fibromata containing many blood-vessels and nerves. The new formations in the breast were merely ordinary mammary fibromata, circumscribed thickening and induration of gland structures. The papillary layer of the skin covering the cutaneous tumors was stretched and thinned, but showed nowhere the localized enlargement of papillæ peculiar to warts.

A close connection if not identity in pathogenesis between the cutaneous fibromata and the tumors found upon the nerves is foreshadowed by the facts, that the newly formed connective tissue in both varieties of tumors is practically the same, and that fibromatous neuromata were often found incorporated in the cutaneous tumors, entering into them from below. The starting-point for the tumors of the skin is probably in the deeper layers of the corium, the vessels, nerves, sweat glands, and hair follicles affording paths favorable to the development of the pathological process. In the false neuromata, also, the morbid process appears to advance along the cylindrical structures contained therein, and the question is, whether such fibroma of the skin did not originally start as a false neuroma, the newly formed tissue advancing along the neighboring glands and vessels. With the idea that the net-like arrangement of the cutaneous tumors was due to the development of fibromata upon a cutaneous plexus of nerve fibres, the author examined this net-work with reference to the ex-

istence of axial nerve fibres, but, as a rule, without success. The most common structure serving as the axis of such bands was found to be a sweat canal, and blood-vessels were even more infrequently detected than nerve fibres. In the plexiform neuromata, however, the bands were not uncommonly found to be the continuation of a nerve fibre.

A second case came under the observation of the author, which aided materially in the solution of this problem; a man, 47 years of age, presenting very much the same appearance as the first case, being covered with cutaneous fibromata. Along the course of several of the subcutaneous nerves also, under entirely unaltered skin, were to be felt isolated thickenings and indurations, like beads upon a string; in all probability false neuromata. Four tumors excised from the back of this patient showed, as in the first case, plexiform arrangement and combination with false neuromata. In these specimens the nerve fibres were found to extend through a great portion of the tumor unchanged. Starting from a nerve trunk which had already undergone fibromatous thickening, as far as the nerve fibres were traceable, they were seen to be surrounded by newly formed, soft, cellular connective tissue. In those portions of the tumor where the newly formed tissue was harder, more distinctly striated, and less rich in cells, the nerve fibres were not to be made out. There was no distinct line of demarcation between these two varieties of connective tissue, and the nerve fibres, as they extended into the harder portions of the tumor, simply vanished, without any trace of degeneration. Sweat canals, hair follicles, and sebaceous glands were absent.

Von Recklinghausen considers himself justified in assuming an identity of pathogenesis for all of these tumors for the following reasons:

- 1st. That these two varieties of tumor were found associated in the same individual.

- 2d. That the newly formed connective tissue present in both varieties of tumor was of the same character.

- 3d. That in the first case fibromata were found connected with muscular and visceral nerves as well as upon cutaneous nerves, and that the fibromata of the periosteum of the tibia were particularly well supplied with nerves.

- 4th. That in both cases the cutaneous fibromata were not uncommonly in intimate connection with nerve fibres.

He concludes that the multiple soft fibromata of the skin originate as neuromata and should therefore be designated multiple neuro-fibromata. After discussing at length the etiology of the multiple neuro-fibromata and their relations to various other pathological processes in the skin, the author concludes with these words: "To return to the idea with which I prefaced these observations upon fibromata, namely, that the different connective-tissue portions of the skin share in the production of new formations, not in equal but in typically different degrees. As this idea

seems to win some foundation from the foregoing facts, I may venture to propose a tabulated schedule which shall indicate this predilection of different morbid processes for diverse portions of the skin. There are associated :

"1. The connective-tissue sheaths of the nerves, vessels, and follicles—neuro-fibromata, leprosy, and elephantiasis mollis.

"2. The lymph vessels—lymphangio-fibromata, elephantiasis lymphangiectodes, and carcinoma.

"3. The serous cavities (saft spalten) and canaliculi (saft kanälen) belonging to the connective-tissue framework of the skin and to the sheaths of the various structures contained therein—acute inflammatory tumors, leukæmic lymphomata, tubercle, lupus, sarcomata, granulomata, and elephantiasis mollis and dura.

"4. The veins—chancre, small-pox, and erysipelas.

"5. The arteries and blood capillaries—chronic inflammatory new formations with a tendency to cheesy degeneration, certain granulomata, and angiomata.

"By adding to this list, callosity, hard (epithelial) warts, adenomata, neuro-papillomata, and ichthyosis congenita as peculiar to the epithelial layers of the skin, we include nearly all dermal tumors. I am well aware that neither the genesis of tumors nor the true nature of pathological processes are explained by such propositions. But neither can we understand the creation of a mountain, without first learning its structure, without first knowing the different strata of which it is composed, and their several directions and extent. It is only by knowing the tendencies of development of pathological products that we are enabled to discover their origin, the points from which they spring."

The book concludes with a complete and condensed summary of all the hitherto published cases of multiple fibromata and neuromata.—*Ueber die multiplen Fibrome der Haut und ihre Beziehung zu den multiplen Neuromen*, Berlin, 1882. Verlag von August Hirschwald.

Rhinophyma.—Dr. HANS VON HEBRA gives the results of microscopical examination of specimens of this disease, and the method of treatment employed by himself. By rhinophyma is designated a neoplasm situated upon the nose, which occasions decided enlargement and marked disfigurement of that organ. As a rule the thickening is not equally distributed, but is irregular, presenting a lobulated and knobbed surface. Sometimes these tumors have a broad base, sometimes they are pediculated, thus acquiring a certain degree of mobility, wabbling about with every movement of the head. The nose is usually red or bluish-red in color, sometimes slate-gray. Upon closer inspection of the surface, dilated blood-vessels may often be recognized, but these are sometimes entirely absent. These tumors are of doughy consistence, their surface glistening and greasy, covered with small orifices, the slightest pressure upon which causes to exude masses of sebaceous matter of an unpleasant and rancid odor. In rare

cases, not only the nose but also the cheeks and regions of the eyebrows are involved. With the exception of localized inconvenience from the presence of these tumors there are no subjective symptoms. Their rate of growth, at first slow, becomes eventually more rapid, the nose reaching in a few years a large size. There is never any suppuration or ulceration, and the growths show no tendency to retrograde. The affection develops after middle life. Histological examination shows the normal elements of the skin in a condition of distorted, irregular hypertrophy. The structures in which this hypertrophy is most manifest are the blood-vessels, connective tissue, and the sebaceous glands, notably the latter, which attain gigantic size, and become transformed into cyst-like bodies. The epithelial layers covering the papillæ is the only tissue not participating in the pathological process. Contrary to Wilson's opinion, the affection has nothing in common with elephantiasis Arabum. Rhinophyma never originates with, nor is accompanied by, inflammatory processes; while the true elephantiasis Arabum consists essentially in hypertrophy of connective tissue due to recurring attacks of erysipelalous inflammation, and in the resulting chronic œdema of the parts. In elephantiasis the œdema, especially in the more recent cases, is so great, that upon incision into the diseased tissues large quantities of albuminous fluid escapes, which is never the case in rhinophyma. In the latter disease the tissues are not soaked with fluid like a sponge, but show infiltration merely of embryonic cells. In elephantiasis the corium and papillary layers take but little share in the pathological process, which is confined to the subcutaneous tissues; directly the opposite being true of rhinophyma, so that periostitis and the consequent new formation of bone, which is so often found in elephantiasis, and notably in a recently reported case of elephantiasis of the nose (*Prager medicin. Wochenschrift*, 1880, Nos. 21, 22, 23), does not occur in rhinophyma.

The only statement which can be made about the etiology of the disease is that it is not confined to persons addicted to the free use of alcohol. The treatment followed by the author with encouraging results, consisted in paring down the excrescences, and carving as good a looking nose as possible out of the shapeless mass. By reason of the existing dilatation of blood-vessels the hemorrhage is often excessive, but may always be controlled by compression. Subsequent treatment is antiseptic and symptomatic, the raw surfaces eventually becoming covered with a layer of sound epidermis, showing here and there only traces of cicatricial tissue.—*Vierteljahresschrift f. Derm. u. Syph.*, viii Jahrgang, 1881, Heft 4, p. 603.

Lupus.—The following conclusions are given by Dr. RAUDNITZ as the result of the statistical examination of 209 cases of lupus. Neither anatomically nor clinically can a difference between scrofulous and idiopathic lupus be made out, the disease appearing in the same form in individuals already scrofulous and in

those entirely healthy. A combination with inherited tuberculosis is only discernible in from ten to fifteen per cent. of all cases. The abscesses of the lymphatic glands so frequently met with in scrofula are almost never found in lupus. A contemporaneous manifestation of lupus in blood relations is seen only in the rarest instances, and hereditary transmission of lupus from parents to children perhaps never takes place. The infrequency of association between lupus and pulmonary tuberculosis decidedly speaks against the identity of these affections. On the other hand the facts, that in at least thirty per cent. of the cases lupus was developed upon or only in the neighborhood of scrofulous cicatrices, or upon mucous membranes already changed by catarrhal processes; that in twelve cases, injury, and in eight cases, local attacks of erysipelas were given as exciting causes, would indicate that lupus is often due to a localized specific predisposition, the nature of which is entirely hypothetical. At all events the small proportion of cases, seventeen in number, in which lupus was found in combination with often trivial affections of the skin, seems to contradict the assumption that in lupus we have to do with a generalized predisposition of the skin to pathological changes.—*Vierteljahresschrift f. Derm. u. Syph.*, ix Jahrgang, 1882, Heft 1, p. 81.

Iodoform in lupus.—Dr. RIEHL has used this drug as a local application in lupus vulgaris with flattering success. In order to remove the epidermis and thus render the diseased tissues accessible to the action of iodoform, a fifty-per-cent. solution of caustic potash was applied to the skin after removal of all dirt and grease from the same by means of washing with soap and water. Left in contact with the skin a caustic solution of this strength in from one half to two minutes caused transparency, swelling, and detachment of the epidermis. This effect produced, the excess of caustic potash was washed off with water, the surface thoroughly dried, and a layer of finely powdered iodoform from one to two millimetres in thickness was applied to the surface which had been denuded of epidermis. This, covered with cotton batting, retained in place by strips of sticking plaster, was left undisturbed for from five to eight days. In no case was there suppuration, and on removal of the dressing the iodoform was found embedded in the depressions due to the disappearance of diseased tissue. Adherent at some points, at others which were in process of cicatrization the iodoform was merely superimposed. The sound skin between the points of pathological infiltration was pale and soft, and the general swelling and redness of the parts had in great measure diminished. In severer cases, while there was never suppuration, two or three successive applications of this dressing were required before the pathological infiltration of the tissues disappeared. The application of iodoform to surfaces of skin denuded of epidermis caused neither pain nor any disagreeable sensations. To do away with the pain necessary to the ap-

plication of caustic potash, local anæsthesia may be used. The author has employed this dressing in twenty cases of lupus, and always with good result.—*Wiener med. Wochenschrift*, 1881, xxxi, p. 534.

Polypapilloma tropicum—frambœsia.—Dr. CHARLOUIS has an interesting article upon this disease in the *Quarterly of Dermatology and Syphilis*. The malady is endemic in the East Indian Archipelago and in the West Indies. It begins with fever ushered in by a chill. The bodily temperature, which is normal in the morning, reaches 39° C. to 40° C. in the evening; the fever rarely lasting longer than fourteen days. Severe pain in the joints, both by day and by night, and lasting about three weeks, accompanies this initial fever. The joints affected are not swollen, but are very sensitive to pressure. About eight days after the first on-come of the fever, papules about the size of the head of a pin, surmounted by a small yellow point, appear gradually, here and there upon the body. These papules are afterward surrounded by a dusky halo, and increase peripherically in size, reaching in some instances a diameter of three centimetres. They are flattened and of a papillary, fungous appearance, whence the name frambœsia. Hard to the touch, and movable only with the skin, they are covered with a honey-like yellowish crust, upon the removal of which is seen a surface of papillary nature overspread with a small quantity of white sticky fluid. These tubercles may present themselves upon any part of the body, head, or limbs, and by their coalition around the mouth and anus, on the penis and elsewhere, ensue larger, circular, and annular plaques. Mechanical irritation of these tubercles may cause long-standing and deep-seated ulcerations. With the appearance of the skin manifestations come swelling, painfulness, and sensitiveness of the lymphatic glands throughout the body. This condition of the glands gradually subsides, although for some time subsequent to the cure of the disease they may remain enlarged and hard. The disease is never fatal, the patients remaining in good general health, notwithstanding the chronicity of the malady, which untreated may last for years. The pathology of the affection is essentially a localized dermatitis, characterized by accumulations of granulation cells, beginning around the smaller blood-vessels. Secondary changes are dilatation of the smaller blood-vessels, of the tubes of the sweat glands, hypertrophy of the papillæ of the skin, of the sebaceous glands, and of the erectores pilorum. Strange to say the nutrition of the hairs is not interfered with, and even when the scalp is the seat of the local skin manifestations, neither temporary nor permanent baldness ensues. The disease is contagious, being both auto- and hetero-innuculable; the point of infection being, as a rule, marked by an ulceration which runs the usual course of an ordinary local venereal ulcer (chancroid). The contagium is fixed, and the period of incubation is from three to five months. Both the blood contained in, and the pathological

excretions from, the tubercles are carriers of contagion, but retain this property only "in stadium incrementi et acmes" of the same, afterward becoming innocuous. The disease is chronic by reason of the continued appearance of new tubercles or groups of tubercles, the older ones meanwhile becoming dried up and disappearing without leaving any cicatrix. The prognosis is good, the malady being very amenable to treatment, which consists in the local application of mercurial ointment to the lesions of the skin and the internal administration of iodide of potassium or iodoform. These latter benefit only the osteocopic pains and in no way influence the course of the tubercles. During the initial febrile stage quinine is given. The many notable points of resemblance between this disease and syphilis have led many observers to regard frambœsia as a modified form of the latter, but the author has decided this point by innoculating two individuals suffering from frambœsia with syphilis. In both the individuals thus innoculated, syphilis was developed and ran its usual course.—*Vierteljahresschrift f. Derm. u. Syph.*, viii Jahrgang, 1881, 2d u. 3d Heft, p. 431.

New remedy for elephantiasis Græcorum (leprosy).—

Dr. E. WESTLUND, starting with the supposition that leprosy might be due to micro-organisms, tried in three cases salicylate of soda with marked effect. The first case was that of a man suffering in a high degree from lepra tuberculosa. Tubercles varying in size from a pea to a hazel-nut were found in the skin of the face, the extremities, the abdomen, the scrotum, and in the throat. The hoarseness of the voice indicated their presence in the larynx. The muscles of the hands were atrophic; the eyebrows had been lost; the hair on the head was thin and dry; the nails thick, curved, and fissured. No ulcerating tubercles. He was advised to take one gram (15 grains) of sodium salicylate five times a day in a tablespoonful of water. The patient wrote after some months to report that he was perfectly cured.

The two other cases were yet under treatment, but had improved very considerably when they were last seen. Translated from *Transact. of Soc. of Physicians in Upsala, Sweden*, vol. vi, No. 1, p. 76, by H. J. Garrigues.

(Recent literature reserved for want of space.)

II.

SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS, ETC.

ARTHUR VAN HARLINGEN, M.D.

The prevention of syphilis.—Dr. J. WILLIAM WHITE, in

an address prepared at the request of the Philadelphia County Medical Society, and read before it Dec. 14, 1881 (*Phila. Med. Times*, Jan. 14, 1882), gives an admirable résumé of the literature of the subject, and presents the argument in favor of preventive measures very strongly. The tone of his address is much more moderate than that usually indulged in by writers on this subject, and is notable for the large proportion of facts and figures, and for the notable absence of vituperation. Indeed, in reading the paper it is difficult to conceive of any serious argument which can be brought forward to combat his views. The desirability, nay, necessity of proper governmental supervision of the illicit relations of the sexes seems obvious. But the weak point is in the means heretofore proposed to attain the end. In this country, certainly no municipal government has as yet shown itself capable of applying more than the simplest sanitary regulations, and it is not likely that the complicated machinery necessary for the regulation of prostitution could be set in motion and kept in working order by the legislators now governing our cities and towns.

Syphilis of the heart.—Only nineteen cases of this rare affection have been hitherto described. To these B. TEISSIER (*Annales de Derm. et de Syph.*, 2me ser. t. iii, No. 6), adds another, essentially as follows: A prostitute, 27 years of age, in the third year of syphilis, which, however, had only manifested itself in the form of buccal mucous patches, was suddenly seized with dyspnoea, followed by asphyxia and death within twenty-four hours. The autopsy showed extensive involvement of the anterior walls of the right ventricle in its upper half, the muscular tissue of which seemed to have become entirely transformed. The thickness of the cardiac wall appeared about normal, but it seemed of a peculiar light gray color, and its consistence much firmer. Section showed numerous milk-white lentil-sized nodules, both in the cardiac walls and elsewhere. These presented a caseous appearance, but were in reality of quite firm consistence, showing no trace of softening even in the centre.

In addition to the interstitial myocarditis and the gummatous deposits, there were considerable vascular alterations in the form of peri-arteritis, endo-arteritis, etc.

Failure of attempts at the inoculation of syphilis in animals.—REBATEL's numerous experiments with syphilitic virus were invariably unsuccessful. In one case of this kind a small incision was made in each groin of a young and healthy bitch. The cellular tissue was then slightly separated by means of a director, and two indurated syphilitic sores which had been excised just before were introduced, and the wounds closed by sutures. Union by first intention took place. A little swelling remained for a few days, but at the end of a week had entirely disappeared. The glands of the groin did not become enlarged, and the animal, though kept under observation for many months, showed no farther symptoms. About the same time, RebateL in-

jected into the jugular vein of a young dog about 150 grammes of defibrinated blood from a patient in whom secondary symptoms were in full activity. This animal, again, showed no signs of syphilis. The offspring of these two animals also, procreated after the performance of these experiments, were perfectly healthy.—*Lyon méd.*, No. 2, 1882; *London Med. Record*.

Syphilitic endo-arteritis with thrombus of left middle cerebral artery.—Mr. ALFRED COOPER reports the case of a man 29 years of age admitted to the hospital in a semi-comatose condition, aphasic and partially hemiplegic, the right side being affected. There was no facial paralysis and no strabismus. The pupils were normal. He was ordered fifteen grains of iodide of potassium three times a day and half an ounce of cod-liver oil twice a day. The patient had had a chancre one year previously, followed by generalized symptoms for which he had been under continuous specific treatment. Symptoms of melancholia early showed themselves, and the hemiplegia and aphasia had first appeared in the sixth month of the disease, but had yielded to iodide of potassium, relapsing four or five months later after neglect. On admission to the hospital there were cerebral pains followed by convulsive movements; the patient grew rapidly worse, and died after some days.

The necropsy showed intestinal peritonitis; membranes of brain healthy; endo-arteritis and thickening of arteries at base, more especially middle cerebral, anterior cerebral, and anterior communicating; thrombus three quarters of an inch long at the commencement of left middle cerebral. Left corpus striatum softened, almost diffuent. Also optic thalamus to a slight extent; rest of brain substance firm and healthy. The early date of occurrence of the cerebral symptoms and the absence of late generalized lesions are interesting points. The peritonitis was apparently intercurrent and unconnected with the syphilis.—*Lancet*, vol. i, 1882, p. 141.

Arthro-meningitis (synovitis) syphilitica in the secondary period of syphilis.—MRACEK, in a thorough-going paper on this subject, which he introduces by a review of its literature, gives some five cases which have come under his own observation, and concludes with the following general review of the subject.

The occurrence of joint troubles in syphilis is not by any means so infrequent as has been supposed, although typical synovitis is not often met with in the earlier periods ("secondary") of generalized syphilis. The joint affection is apt to be induced by traumatic influence, irritation or exposure to cold. The knee joint is that which is most frequently attacked, probably because of its extensive synovial surface exposing it more easily to injury. Relapses are common. Imperfect and irregular treatment appears to predispose to joint affections.

Whether the synovial membrane is involved over its whole sur-

face or whether the affection occurs in patches like the exanthemata, is not as yet decided, as no pathological examinations of joints in this stage have been made up to the present time. It is probable, however, that even if the syphilitic deposit occurs only in limited patches, the neighboring synovial membrane for some distance around is more or less inflamed. The perisynovial connective tissue is likewise involved in chronic cases, and such an amount of thickening occurs as hinders perfect extension and flexion and shows by external signs the progress of the disease. The synovial fluid, which is not usually found poured out to any considerable amount, shows, as in ordinary arthro-meningitis an admixture of desquamative epithelial scales thrown off from the inflamed and infiltrated synovial membrane, and also fibrinous coagulations and exuded blood. The involvement of the cartilage, at least in places, is indicated by the rubbing sounds sometimes heard on movement of the joint.

Patients who suffer from syphilitic synovitis often complain, even in the prodromal stage of the disease, of rheumatoidal pains in the joints. Many such cases, however, quickly recover. Even when some slight exudation may have taken place, a few weeks suffice to relieve the stiffness and pain. Some cases, however, go on to a further development, especially if the treatment has been inadequate or if the joint has been submitted to further injury. The patients now complain of increasing pain, aggravated at night and accompanied by more or less marked swelling.

Recent cases recover rapidly because the joint is only superficially affected. New chronic cases, however, are cured with difficulty, and are very apt to have stiffness and impaired movement, with thickening of the synovial membrane and perisynovial connective tissue, and occasional grating when certain movements of the joints are made. The prognosis, however, is generally good if appropriate treatment, external and internal, be employed and the joint guarded carefully. Of course there is a strong tendency to relapse in any case of synovitis, but when, as in syphilis, the diathesis is present and constantly predisposing to relapses, these must necessarily be still more common. Even when there is no particular injury or exposure of the joint a recrudescence of the diathesis often leads to renewed development of the joint trouble.

Among the subjective symptoms the nocturnal pains in the acute form, and the annoying stiffness and constriction of the affected joints in chronic cases, are most prominent. There does not appear to be any necessarily accompanying rise of temperature so far as Mracek's cases showed, but other observers have noted a rise.

The accompanying symptoms, early syphilodermata, etc., have nothing peculiarly characteristic about their appearance.

The diagnostic points are as follows: without any particular cause, or at most only some slight irritation or injury, one or more joints become inflamed; the inflammation does not run a

very acute course ; there is a moderate effusion into the joint which becomes swollen, but the skin covering it does not become red, and there is little or no increase of temperature. The patient usually shows concomitant syphilitic symptoms on the skin and mucous membranes, or the pain dates back to the appearance of an exanthem. The further course of the disease and its disappearance under specific treatment confirm the diagnosis.—*Wien. med. Presse*, Nos. 1, 2, 3, 4, and 5, 1882.

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SYPHILIS OF THE NERVOUS SYSTEM.

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The association of tabes dorsalis with syphilis.—THOS. BUZZARD writes as follows: "Tabes dorsalis is the most frequent of all the chronic affections of the cerebro-spinal axis, and the prognosis in this disease is practically hopeless. There is increasing evidence, no doubt, to show that cases may go on for a very long time without the symptoms becoming materially intensified, and even with encouraging periods of improvement. But as matters stand we are unable to count upon more than this in any case of a confirmed character. At first sight, therefore, it would seem to be a point of more than ordinary importance to discover whether the disease is so far connected with a syphilitic origin as to encourage us to hope for success by treating the patient energetically with specific remedies. In many morbid conditions such a discovery, by leading to appropriate treatment, produces the most triumphant results. But as a matter of fact, in the case of tabes dorsalis, expectations that may have been formed of a similar success here have not been realized. Now and then, it is true, we meet with cases which improve remarkably for a time while iodide of potassium is being administered, but in my experience I have never known a cure to result from specific measures. From the mercurial treatment, indeed, which I have had very carefully applied by inunction in a number of cases when the history of syphilis was distinct, I have seen no good whatever, but, on the contrary, as it seemed to me, a tendency to harm. In 1871, writing upon the subject of syphilitic affections of the nervous system,

I included locomotor ataxia among the nervous affections belonging to the tertiary stage of syphilis. At that time the frequency with which a syphilitic history was to be noted in these cases had long impressed me, and I was in the habit of treating my ataxia patients with iodide. But the remarkable absence of successful results appeared to throw so much doubt upon the matter that I carefully excluded the disease from consideration in my work on syphilitic nervous affections. The connection between nervous disorders and syphilis was then not generally recognized, and I was anxious to avoid weakening the force of that which was to be said on a very important subject by the introduction of debatable material. * * * If we take the statistics of Fournier, Erb, and myself, we shall find that in 59 per cent. there was a history of syphilis. It is certain that coincidence is not sufficient to establish any thing like a necessary relation. It is necessary also to bear in mind another very possible source of fallacy. There is often great difficulty in ascertaining the earliest symptoms of tabes. There may have been some slight flying pains which have left little or no mark in the recollection of the patient, and in nine cases out of ten they have been set down by him as rheumatism. Yet these pains, usually the earliest evidence of tabes, may have occurred *before* he became affected with syphilis. The position of tabes in regard to syphilis is peculiar in another respect. Affections of the nervous system, which owe their origin to syphilis, are not, as such, distinguishable in any very evident manner from disease unconnected with such affection. As a matter of experience, it is certain that almost all cases of marked paralysis of the cranial nerves (I exclude here the incomplete and transitory paralysis seen in tabes) are due to syphilis. If tabes be of syphilitic origin, how is it that females, who bear their fair share of other diseases of the nervous system of specific origin, furnish only ten per cent. to the ranks of the former disease? While it appears to me unaccountable that there is a remarkable frequency of association between syphilis and tabes dorsalis, I do not think, all things considered, that the time has yet arrived for us to draw safe inferences as to the precise nature of the relations."—*Lancet*, London, June 10, 1882, p. 391.

To what extent is syphilis the cause of tabes, and what are the results of an anti-syphilitic treatment of the latter.—Prof. LEYDEN, of Berlin, expresses his views as follows: "Although I willingly acknowledge that the theory of syphilitic tabes numbers among its adherents names of good scientific repute, yet I must declaim most decidedly against this theory, and refuse to recognize an etiological connection between syphilis and tabes."

He then reviews the opinions of others on this subject, referring particularly to Erb's contributions. [See ARCHIVES OF DERMATOLOGY, vol. viii, p. 87.] After calling attention to the fact that Erb is not a dualist respecting syphilis, which must

affect his statistics, and showing that his argument rests entirely upon statistics, he says: "Statistics in medicine are valued highly by many. I am not a great respecter of them. I claim distinctly that upon statistics alone no proof can be founded. They may support other proof, but are not alone able to furnish an etiological demonstration. All considered, I am forced to the conclusion that the statistical relations of this question prove *absolutely nothing*. It is, however, on this basis alone that the whole theory of syphilitic tabes is founded. * * * Respecting treatment, for my part I find that the anti-syphilitic treatment of tabes furnishing *nothing*, * * *—except that I know of examples of repeated inunctions having reduced the tabetic so low that the injury was irreparable.* * * The last point is one which Lancereaux in particular has emphasized; namely, that the pathological anatomy of tabes is entirely different from that of the syphilitic process. This would be simply false if, as claimed, syphilis frequently transmuted diffuse changes in the substance of the central nervous system. The changes which syphilis produces are of a local nature. Accounts of the anatomical changes in syphilis of the spinal cord are not numerous in literature. They are absent, for the reason that such affections are rare, and autopsies rarer. We are better acquainted with syphilitic diseases of the brain, and we are justified in drawing a certain parallel between the brain and the cord. In the brain we recognize as syphilitic processes, circumscribed gummatous meningitis, also syphilomata, and, finally, softening, which is to be referred to syphilitic arterial disease. Of these processes we know a few which have their analogies, though rarely, in the cord. Circumscribed meningitis, particularly in the cervical regions, has been frequently described. Wagner observed a case of syphiloma. The arterial disease has been recently investigated by Prof. Baumgarten, and a correspondence found between brain and cord, circumscribed myelitic softening as a result of syphilis has also been observed. I have myself described such a case (*Charité Annalen*). Sclerosis as a result of syphilis may be spoken of, but only as circumscribed foci. All these lesions are circumscribed, and, in the main, entirely different from that form to which tabes belongs. If, finally, it be asked under what symptoms does syphilis of the cord develop? The reply would be, according to my experience, always with the signs of a circumscribed myelitis or myelo-meningitis. I have seen a not inconsiderable number of such cases which involve one extremity or, as a rule, both, and, besides paresis, present symptoms of rigidity of greater or less intensity. More frequently than in the cord, syphilitic processes are established in the medulla oblongata, as apoplectiform or subacute bulbar paralysis. For these cases foci of softening have been demonstrated in the substance of the medulla and pons in connection with disease of the arteries (branches of the basilar). In the extraordinarily severe cases of this kind, obliteration of the basilar artery occurs.

(Grusingen one case, Eichorst one case, Leyden two cases.) These rare cases of obliteration of this artery all appear to depend upon syphilis.—*Zeitschr. f. klin. Med.*, iv, p. 475.

On the relation between syphilis and tabes.—Dr. PUSINELLI found in 51 cases of tabes that 16 were affected with, or gave a history of, syphilis (16 per cent.). He concludes from the irregular relations existing between the two diseases respecting succession in time and the severity of the phenomena, that there is the possibility of an alternating action dependent on both diseases, in which, on the one hand, with an existing predisposition to tabes, syphilis would act as an additional factor in the development of tabes; while, on the other hand, the saturation of the system with syphilitic poison may act as a predisposing cause of tabes, particularly when combined with other injurious influences tending to produce tabes. The facts of pathological anatomy fail to decide the question whether there is alone degeneration of the posterior columns dependent on syphilis, and the therapeutical facts of his cases furnish no indication of a connection between tabes and syphilis; for antisymphilitic treatment in numerous cases was of doubtful effect, and in one case mercurial inunctions resulted injuriously. He concludes that while statistics lead to the suspicion of a connection between the two diseases, all proof of such a connection is still absent.—*Archiv f. Psych.*, u. s. w. xii, 3.

Gummatous arteritis of the central nervous system.

—Prof. BAUMGARTEN, of Königsberg, gives his views on this subject as follows: *Arteritis gummosa* represents nothing else than a chronic granulating arteritis, whose products, whether of a diffuse or a tumor-like form, on the basis of ordinary chronic interstitial inflammation tissue, are characterized by a tendency to caseous tissue necrobiosis. It is precisely the same condition for the artery as the “hepatitis gummosa” is for the liver and the “orchitis gummosa” is for the testicles: but as in these organs, aside from the gummatous form, a simple chronic interstitial inflammation also occurs, which fails to reach the “specific acme” attained by the first, so it is in the artery. Along with the gummatous form there was also a chronic interstitial inflammatory form. This constitutes Heubner’s “syphilitic disease of the cerebral arteries,” according to whom the commencement of the specific process occurs in the internæ; growths of the exterior arterial coats being secondary phenomena, the result of simple inflammatory irritation. According to the author, on the other hand, both forms begin as a granulating inflammation of the external coat, the interna becoming involved later, as an anatomically secondary phenomenon. The difference between “arteritis gummosa” and “arteritis syphilitica simplex” consists alone in the fact that with the first the granulating neoplasms—mostly those of the adventitia and media only, but in higher degrees of intensity those of the internæ also—may continue to develop until gummata are produced, while the growth of the second

form remains at the level of simple chronic inflammatory new formations, and, like the latter, are converted directly into cicatricial tissue—that is, without undergoing caseous degeneration.—*Virchow's Archiv*, Bd. 86, p. 218.

Syphilis of the spinal cord.—Dr. F. GREIFF calls attention to the imperfection of our knowledge on this subject, compared with that of cerebral syphilis. The anatomical changes found in the latter consist of specific neoplasms, either as circumscribed gummata or diffused gummatous infiltration; specific inflammatory changes in the meninges and adjacent cerebral substance; and, finally, syphilitic disease of the cerebral arteries and its effects, first described by Heubner. Reviewing the literature of syphilis of the cord he finds: (1) Cases of circumscribed gummata, in some originating from the envelopes of the cord, and in others developing in the cord itself (cases of Rosenthal, Macdowell, Wills, Wagner, Hales). (2) Diffused neoplasms (cases of Zambaco, Bruberger, Westphal, Heubner). (3) Inflammatory changes in the meninges with additional changes in the cord itself (cases of Homelle, Winge, Charcot and Gumbault, Schultz, Julliard). No description is to be found of true specific diseases of the vessels of the spinal cord. The dilated vessels with thickened walls surrounded with cellular infiltration, described by some authors, as they appear under entirely different conditions, also cannot be acknowledged as specific. The same doubt must remain in all cases where inflammatory changes in the cord or its membrane are unaccompanied by specific gummatous tissue. The problem of determining the characteristic anatomical relations of syphilitic myelitis, notwithstanding many attempts, remains, he thinks, unsolved. He gives an abstract of thirteen cases with autopsies, and refers in detail to Julliard's views, who considers that the confined presence of inflammatory process in the meninges, of exudative process in the vessels and their sheaths, and the hyperplasia of the neuroglia with its effects upon the neural elements, constitute the features of syphilis of the spinal cord. The pathological process involving principally the lymphatic system of the cord entering through the meninges, the neuroglia, and vascular sheaths, it follows that the changes may be diffuse, but they cannot constitute a "systematic" disease. If the process be a rapid one, softening follows; if slow, sclerosis. The author reports very fully his own case, in which the changes consisted of an extensive inflammation of the pia mater, in some parts at an early stage, in others advanced; decided disease of the arteries and veins; also swelling and hyperplasia of the interstitial tissue, with inflammatory exudation around the vessels and moderate involvement of the neural element. The arterial changes were the same as those described by Heubner for the brain, observed with certainty, according to the author, for the first time in the cord; a peculiar obliteration of the veins also existed. No softening or decided "systematic" lesion was found. He concludes that the facts of this case sup-

port Julliard's views, and furnish undoubted proof of the existence of syphilitic diseases of the arteries of the cord. But while the changes in the meninges and vessels appear to be undoubtedly of a specific character, the changes in the cord, on the contrary, exist only in connection with and dependent upon the former, which together represent the true characteristics of syphilis of the spinal cord.—*Archiv f. Psych.*, xii, 3.

Syphilitic meningeal irritation.—Under this title, Prof. E. LANGE describes a group of symptoms, consisting of pain distributed over the entire cranium or limited to the frontal or occipital region, frequently in the form of painful band from one ear to the other, or of a constriction of the head horizontally. In one case it appeared as an occipital neuralgia; aside from this vertigo, loss of appetite, occasionally vomiting, and mental depression were present. These conditions are of comparatively short duration. They occur as early symptoms of syphilis. Ophthalmoscopic examination of cases of beginning syphilis, examined at the author's suggestion by Prof. Schnable, revealed, with considerable frequency, retinal irritation of varying intensity, an inflammatory process of the retina or choroid, or of both together, without complaint of ocular trouble by the patient. On this slender basis Prof. Lange constructs his theory of meningeal irritation, namely, that in these cases there exists a condition of hyperæmia, or very slight meningitic conditions bordering on inflammation of the membranes. He holds, with Hutchinson, that syphilis proper is concluded with its earlier symptoms, and that the so-called later forms are to be interpreted as sequelæ, as in the case of the acute exanthemata, the syphilitic contagion having so changed the issues that for years external influences continue to excite pathological changes of a gummatous nature.—*Bericht des naturw. med. Vereins, Innsbende*, 1880-1, lxx; *Vierteljahr. f. Dermat.*, Wien, 1881, viii, p. 469.

(Recent literature reserved for want of space.)

Miscellany.

American Dermatological Association.—The sixth annual meeting of the American Dermatological Association will be held at Newport, R. I. on the 30th and 31st of August and 1st of September, 1882.

ARTHUR VAN HARLINGEN, M.D., *Secretary*.

Reviews and Book Notices.

De la Syphilis des Verriers, Hygiène et Prophylaxie par la Visite sanitaire, par le Dr. Guinand, Paris, 1881, pp. 64.

This pamphlet, which derives its main interest from the information it furnishes concerning the methods employed in the manufacture of bottles in the largest glass-factories of France, comprises a paper read before a meeting of the National Society of Medicine of Lyons, of November 30, 1881, and the discussion which followed it, participated in by Drs. Diday, Chassagry, Rollet, and others.

From it we learn that Rive-de-Gier, which is to-day, from the industrial point of view, the most important centre of the manufacture of glass in France, was twenty years ago, from the medical point of view, the first and principal centre of observation of syphilis transmitted by glass-blowing. It was upon a workman in one of its factories that M. Rollet first recognized and demonstrated, in 1859, the contagiousness of secondary lesions.

After minutely describing the methods of manufacture in these establishments, the pamphlet speaks of the accidents which may be caused by the work of the glass-makers. They arise from the use of the tube, the glare of the light, the intensity of the heat, and, finally, from blowing the glass. The weight, the heat, and the movements of rotating the tubes produce certain effects upon the hands and the mouth, lips and throat. At first there is produced an inflammation of the skin, and, later, blebs and bullæ of the palms. The epidermis soon becomes hardened, however; and of a yellow color, from the heat of the tube. After one or two months enormous masses of epidermis form on the palms, most prominent on the hypothenar eminence in the first interdigital space, and on all the prominent parts of the fingers. They are much more marked on the left hand, which is placed nearer the mass of molten glass at one end of the tube, than on the right. These epidermic callosities frequently crack, and become the seat of deep fissures, which are often so painful as to prevent further work. The heat of the tubes also frequently leads to the formation of small subcutaneous abscesses.

The glare of the white light from the furnaces is a frequent source of visual disorders. Cataract is much more common among glass-blowers than in those who follow other occupations, and occurs in much younger subjects.

The effect of the intense heat to which the workmen are exposed is manifested by burns of the first degree upon the prominent parts of the face, manifested by erythema, or a characteristic marbling. These lesions give the face a peculiar expression by which the trade of the man may be recognized.

The heat subjects the majority of the workmen to an abundant perspiration, which leads them to drink enormous quantities of liquid. When the perspiration is suddenly arrested, on quitting work, many of the men are seized with phenomena of indigestion and vomiting of large quantities of water.

The lesions produced by blowing the glass the author divides into mechanical, physiological, and those arising from contagion. The former comprise those produced by the pressure of the end of the tube on the lips and gums, which causes great desquamation of epithelium and fissures of the middle of the lower lip. Many workmen have constantly in this situation a more or less deep fissure, which the friction of the tube maintains in a condition of callous ulceration. This often furnishes a point of entrance for the syphilitic contagion.

The compression of the air in the mouth during the blowing process excites a condition of chronic inflammation of the whole mucous membrane of this cavity, manifested particularly in the back of the throat by a diffuse vinous redness, and on the free edges of the gums by a sub-inflammatory border. The latter are frequently swollen and ulcerated. The most constant and striking lesions are, however, two bilateral and symmetrical patches, which the author designates "professional," because they are only found in glass-blowers, and particularly in bottle-makers. They exist in a more or less pronounced form in nearly all those who have followed the calling for several years, and are constantly situated on the median and superior wall of the membrane lining the cheeks.

In those who have worked but a short time, there is noticed around and especially above the openings of Steno's ducts a very striking vascular arborescence. The membrane remains for some time of a deeper color, and finally becomes of a milky whiteness; the epidermis becomes thickened and wrinkled, and is often detached in the form of a transparent veil, under which the rosy color of the membrane may be distinguished.

The opening of the salivary duct soon becomes dilated; its edges become red and turgescient, and frequently project from the centre of the patch like a nipple. In all glass-blowers the buccal openings of the parotid glands are very distinct and discharge a large quantity of saliva. Old glass-blowers frequently remove pellicles of epidermis from the patches around the ducts. In rare instances the sphincter of the duct of Steno yields under the pressure of the air which penetrates into its interior. In such cases, every time the person

blows, one sees from without the duct become distended, irregularly tumefied, passing under the masseter muscle as far as the lobule of the right ear, forming a hernia in the middle of the cheek sometimes as large as a hen's egg. In one old workman the air penetrated into the duct every time he moved his jaw in speaking, and he finds it necessary to press upon it with the hand in order to expel the air. In such cases the swelling is not painful, and does not interfere with work.

These "professional patches," when small and but slightly developed, bear a perfect resemblance to syphilitic mucous patches. They are distinguished from these by their bilateral symmetry, and by their constant situation around the orifice of Steno's duct, Later they become much thicker, but never ulcerate; whereas old syphilitic patches are not so white, are less wrinkled, and always tend to ulcerate.

That abundant opportunity for direct syphilitic infection is furnished by glass-blowing, is shown by the statement that three workmen pass the same tube from mouth to mouth 75 to 85 times hourly. Three epidemics produced in this manner are described in detail. In order to guard against their recurrence, bi-mensual inspections of all the workmen were instituted in some establishments, no one being employed without presenting a certificate of health from the physician in charge. These examinations, although successful in preventing further accidents, being objected to by some of the workmen, the attempt was made to introduce the use of movable mouth-pieces for the tubes, one being furnished each workman. Although this device seemed to answer the purpose at first, it was soon discovered that the men would not use them, and the occurrence of several new cases of buccal chancres caused the bi-monthly inspections to be resumed.

W. T. A.

ARCHIVES OF DERMATOLOGY

OCTOBER, 1882.

Original Communications

ANALYSIS OF 8,000 CASES OF SKIN DISEASE.

BY L. DUNCAN BULKLEY, A.M., M.D.,

ATTENDING PHYSICIAN FOR SKIN AND VENEREAL DISEASES AT THE NEW YORK HOSPITAL, OUT-PATIENT DEPARTMENT; LATE PHYSICIAN TO THE DEMILT DISPENSARY, NEW YORK,
ETC.

WHILE statistical details appear at first sight to be of comparatively little service, they are of undoubted value as a contribution to the medical history of a country and nation, and as a means of comparing its diseases with those in other lands; in the present instance the attempt will be made to use the presentation of figures as a basis from which practical conclusions may be drawn from the cases here analyzed.

The following tables are taken from records of eight thousand personal cases of diseases of the skin, of which 2,583 were observed in private practice, and 5,417 in my clinics in the Demilt Dispensary, and the out-patient departments of the New York and Bellevue hospitals. The many cases seen in other institutions and casually in hospitals and elsewhere are not included, because records of them have not been kept with sufficient accuracy. A portion of these cases have been included in clinical reports published some years since,¹ and brief mention is made of

¹ "Analysis of 1,000 Cases of Skin Disease," *American Practitioner*, May, 1875.

"Analysis of 617 Cases of Skin Disease," *American Practitioner*, April, and May, 1876.

"Analysis of 774 Cases of Skin Disease," *New York Medical Journal*, April and June, 1877.

the total number in my recent "Manual of Diseases of the Skin"; a more extended consideration is here offered. The cases are arranged in two tables. Table I exhibits the diseases in alphabetical arrangement, and gives also the sex of the patients, and the number in each class of practice separate.

TABLE I.

DISEASES ARRANGED IN ALPHABETICAL ORDER.

DISEASE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
Abscessus	1	1	2	9	7	16	17
Acne	150	370	520	169	284	453	973
Adenoma	4	1	5	4	1	5	5
Alopecia	46	23	69	13	7	20	89
Anthrax	5	1	6	3	2	5	11
Atrophia cutis	2	2	4	2	2	4	6
Bromidrosis	1	1	2	2	2	4	6
Cacotrophia cutis	2	2	4	2	2	4	6
Canities	1	1	2	1	1	2	3
Carcinoma cutis	2	2	4	3	3	6	12
Cellulitis	1	1	2	1	1	2	3
Chloasma	2	30	32	10	10	20	42
Clavus	3	4	7	4	7	11	18
Congestio folliculorum	1	1	2	1	1	2	3
Cornu cutaneum	1	1	2	1	1	2	3
Dermatalgia	1	1	2	1	1	2	3
Dermatitis	20	14	34	66	72	138	172
Dermatitis exfoliativa	2	2	4	3	1	4	6
Dysidrosis	2	1	3	1	3	4	7
Ecthyma	1	1	2	10	7	17	18
Eczema	529	349	878	873	928	1,801	2,679
Elephantiasis Arabum	1	1	2	2	2	4	6
Ephelide	1	1	2	1	1	2	3
Epithelioma	26	19	45	24	17	41	86
Erysipelas	3	3	6	31	54	85	91
Erythema	16	24	40	27	61	88	128
Excoriationes	2	1	3	2	1	3	3
Folliculitis capitis	1	1	2	1	1	2	3
Furunculus	15	13	28	58	65	123	151
Hæmophilia	1	1	2	1	1	2	3
Herpes	14	7	21	26	23	49	70
Hydroa	5	1	6	2	1	3	9
Hyperæsthesia cutis	2	2	4	2	2	4	6
Hyperidrosis	5	3	8	11	8	19	27
Hypertrichosis	1	23	24	1	24	25	26
Ichthyosis	10	5	15	7	6	13	28
Impetigo	2	5	7	5	8	13	13
Impetigo contagiosa	2	5	7	7	12	19	26
Impetigo herpetiformis	2	2	4	2	2	4	6
Keloid	3	4	7	4	4	8	11
Lentigo	1	2	3	1	2	3	3
Lepra	4	4	8	2	2	4	6
Leucoderma	9	8	17	2	1	3	20
Lichen	29	15	44	43	61	104	148
Lupus	11	21	32	7	30	37	69
Lymphadenoma	1	1	2	1	1	2	3
Lymphangioma	1	1	2	1	1	2	3
Macula pigmentosa	2	2	4	2	2	4	6
Miliaria	1	1	2	1	1	2	3
Morbilli	1	3	4	1	1	2	3
Morphea	1	4	5	1	2	3	8

TABLE I.—Continued.

DISEASE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
Nævus.	4	12	16	3	7	10	26
Neuroma. . . . .	..	..	..	2	..	2	2
Onychatrophia. . . . .	..	..	..	2	..	2	2
Onychia.	2	4	6	6	5	11	17
Papilloma.	3	..	3	2	..	2	5
Paronychia. . . . .	..	..	..	1	4	5	5
Pemphigus.	3	7	10	2	5	7	17
Phlegmon. . . . .	..	..	..	1	..	1	1
Phthiriasis.	3	8	11	155	231	386	397
Pityriasis.	5	12	17	4	14	18	35
Pompholix.	4	..	4	..	..	..	4
Prurigo. . . . .	..	1	1	..	..	..	1
Pruritus.	23	17	40	55	57	112	152
Psoriasis.	77	54	131	92	110	202	333
Purpura.	9	2	11	12	16	28	39
Rhinoscleroma. . . . .	..	1	1	..	..	..	1
Roseola. . . . .	..	..	..	1	5	6	6
Rötheln.	3	8	11	..	1	1	12
Sarcoma.	2	..	2	1	..	1	3
Scabies.	9	1	10	66	52	118	128
Scarlatina. . . . .	..	1	1	..	..	..	1
Scleroderma.	1	2	3	..	1	1	4
Scrofuloderma.	1	2	3	14	13	27	30
Strophulus pruriginosus. . . . .	..	..	..	..	1	1	1
Sycosis.	15	..	15	12	..	12	27
Syphilis.	92	61	153	344	302	646	799
Syphilophobia. . . . .	..	..	..	..	1	1	1
Telangiectasis. . . . .	..	1	1	..	1	1	2
Tinea.	87	37	124	142	94	236	360
Trichorexis nodosa.	4	..	4	..	..	..	4
Tumor. . . . .	..	..	..	1	2	3	3
Tylosis. . . . .	..	..	..	..	1	1	1
Ulcus.	8	6	14	88	79	167	181
Urticaria.	14	30	44	62	93	155	199
Vaccinia. . . . .	..	..	..	2	..	2	2
Varicella.	3	3	6	9	6	15	21
Varicella prurigo. . . . .	..	..	..	2	..	2	2
Variola.	4	1	5	..	..	..	5
Varioloid. . . . .	..	..	..	1	..	1	1
Verruca.	5	9	14	30	11	41	55
Xanthoma.	2	4	6	1	3	4	10
Xeroderma.	4	2	6	2	2	4	10
Zoster.	14	12	26	30	32	62	88
Doubtful diagnosis.	2	1	3	5	4	9	12
	1,320	1,263	2,583	2,577	2,840	5,417	8,000

Table II presents the diseases arranged in the order of their relative frequency, and shows the percentage of each. This table enables a comparison of the proportion of various diseases in private and public practice, which will be found to vary very considerably in some instances. Thus acne forms 20 per cent. of cases in private practice, and only 8 per cent. of those in public practice; syphilis was presented but half as often in private as in public practice; the animal parasitic affections were very seldom seen among private cases, whereas the vegetable parasitic diseases occurred in about equal frequency in both, etc.

TABLE II.

DISEASES ARRANGED IN THE ORDER OF THEIR RELATIVE FREQUENCY.

DISEASE.	Private Practice.		Public Practice.		Totals.	
	Num-ber.	Per cent.	Num-ber.	Per cent.	Num-ber.	Per cent.
1 Eczema {infantile	115	87.8	488	1,801	603	2,679
{over 5 years of age.	763		1,313		2,076	
{sebacea	68	52.0	40	453	108	973
{punctata	14		45		59	
{molluscum	6		2		8	
{simplex	226		212		438	
{indurata	56		53		109	
{rosacea	150		101		251	
3 Syphilis	153	5.93	646	11.88	799	9.99
4 Phthir-iasis {capitis	7	11.43	221	386	228	397
{corporis	1		146		147	
{pubis	3		5		8	
{phthiriophobia .....	..		3		3
{		11		11	
5 Tinea {tricho- {capitis	31	12.4	43	236	74	360
{phytina {barbæ	8		16		24	
{ {corporis	27		80		107	
{ {cruris	25		11		36	
{versicolor	30		57		87	
{favosa	3		28		31	
{onychchia parasitica		1		1	
6 Psoriasis	131	5.07	202	3.72	333	4.16
7 Urticaria	44	1.66	155	2.85	199	2.49
8 Ulcus {venereum	4	14.54	46	167	50	181
{simplex	10		121		131	
9 Derma-titis {simplex	11	34.13	48	138	59	172
{venenata	13		27		40	
{medicamentosa	9		8		17	
{calorica	1		27		28	
{traumatica .....	..		28		28
10 Pruritus {hiemalis	15	40.155	8	112	23	152
{senilis	2		20		22	
{gravidarum	1		1		2	
{	22		83		105	
11 Furunculus	28	1.08	123	2.27	151	1.89
12 Lichen {simplex	30	44.172	87	104	117	148
{planus	12		12		24	
{pilaris	1		4		5	
{scrofulosorum .....	..		1		1
13 Erythema {multiforme	24	40.155	37	88	61	128
{simplex	11		41		52	
{nodosum	4		9		13	
{scarlatiniforme	1		10		2	
14 Scabies	10	.39	118	2.18	128	1.6
15 Erysipelas	6	.23	85	1.57	91	1.14
16 Alopecia {areata	32	69.267	14	20	46	89
{	37		6		43	
17 Zoster	26	.91	62	1.14	88	1.10
18 Epithelioma	45	1.74	41	.76	86	1.08

TABLE II.—Continued.

DISEASE.	Private Practice.		Public Practice.		Totals.	
	Num-ber.	Per cent.	Num-ber.	Per cent.	Num-ber.	Per cent.
19 Herpes { febrilis..... { progenitalis..... { gestationis..... { lab. maj..... { nasalis..... { linguæ.....	4 13 4	21	36 6 .. 1 1 1	49	40 19 4 1 1 1	70
20 Lupus { erythematosus..... { vulgaris..... { senilis.....	20 12 3	32 .. 14	22 15 4	37 .. 41	42 27 55	69 .. 7
21 Verruca { simplex..... { hæmorrhagica..... { rheumatica.....	7 2 2	11	21 4 3	28	28 6 5	39 .. 49
24 Pityriasis.....	17	.66	18	.33	35	.43
25 Scrofuloderma.....	3	.12	27	.5	30	.38
26 Ichthyosis { congenital.....	2 13	15 ..	13	.24	28	.35
27 Hyperidrosis.....	8	.31	19	.35	27	.34
✓ 28 Sycosis.....	15	.58	12	.22	27	.34
✓ 29 Impetigo contagiosa.....	7	.27	19	.35	26	.33
30 Nævus { vasculosus..... { pilosus..... { pigmentosus..... { araneus.....	10 2 2 2	16	9 1	10	19 3 2 2	26
31 Hypertrichosis.....	24	.93	.....	.....	24	.3
32 Varicella.....	6	.23	15	.28	21	.28
33 Leucoderma.....	17	.66	3	.055	20	.25
✓ 34 Ecthyma.....	1	.039	17	.31	18	.22
35 Abscessus.....	1	.039	16	.3	17	.21
36 Onychia.....	6	.23	11	.2	17	.21
37 Pemphigus.....	10	.39	7	.13	17	.21
✓ 38 Impetigo.....	.....	.....	13	.24	13	.18
39 Rôtheln.....	11	.43	1	.018	12	.15
40 Anthrax.....	6	.23	5	.09	11	.14
41 Keloid.....	7	.27	4	.07	11	.14
42 Xanthoma.....	6	.23	4	.07	10	.12
43 Xeroderma.....	6	.23	4	.07	10	.12
44 Hydroa.....	6	.23	3	.055	9	.11
45 Morphœa.....	5	.19	3	.055	8	.10
46 Clavus.....	.....	.....	7	.13	7	.09
47 Dysidrosis.....	3	.12	4	.07	7	.09
48 Atrophia cutis.....	4	.15	2	.037	6	.075
49 Dermatitis exfoliativa.....	2	.076	4	.07	6	.075
50 Lepra.....	4	.15	2	.037	6	.075
51 Roseola.....	.....	.....	6	1.11	6	.075
52 Adenoma.....	.....	.....	5	.09	5	.062
53 Carcinoma cutis.....	2	.078	3	.055	5	.062
54 Morbilli.....	4	.15	1	.018	5	.062
55 Papilloma.....	3	.12	2	.037	5	.062
56 Paronychia.....	.....	.....	5	.09	5	.062
57 Variola.....	5	.19	.....	.....	5	.062
58 Pompholix.....	4	.15	.....	.....	4	.05
59 Scleroderma.....	3	.12	1	.018	4	.05
60 Trichorexis nodosa.....	4	.15	.....	.....	4	.05
61 Bromidrosis.....	1	.039	2	.037	3	.042
62 Canities.....	2	.078	1	.018	3	.042
63 Cellulitis.....	.....	.....	3	.055	3	.042
64 Elephantiasis Arabum.....	1	.039	2	.037	3	.042
65 Excoriations.....	.....	.....	3	.055	3	.042
66 Lentigo.....	3	.12	.....	.....	3	.042
67 Sarcoma.....	2	.078	1	.018	3	.042
68 Tumor.....	.....	.....	3	.055	3	.042
69 Cacotrophia cutis.....	2	.076	.....	.....	2	.025
70 Cornu cutaneum.....	1	.093	1	.018	2	.025
71 Dermatalgia.....	2	.078	.....	.....	2	.025
72 Hyperæsthesia cutis.....	..	.....	2	.037	2	.025

TABLE II.—*Continued.*

DISEASE.	Private Practice.		Public Practice.		Totals.	
	Num-ber.	Per cent.	Num-ber.	Per cent.	Num-ber.	Per cent.
73 Impetigo herpetiformis.....	2	.078	.....	....	2	.025
74 Lymphangioma .....	..	....	2	.037	2	.025
75 Macula pigmentosa.....	..	....	2	.037	2	.025
76 Neuroma .....	..	....	2	.037	2	.025
77 Onychatrophia.....	..	....	2	.037	2	.025
78 Telangiectasis.....	1	.078	1	.018	2	.025
79 Vaccinia.....	..	....	2	.037	2	.025
80 Varicella prurigo.....	..	....	2	.037	2	.025
81 Congestio folliculorum.....	..	....	1	.018	1	.0125
82 Ephilide	1	.039	.....	....	1	.0125
83 Folliculitis capitis .....	..	....	1	.018	1	.0125
84 Hæmophilia.....	..	....	1	.018	1	.0125
85 Lymphadenoma.....	1	.039	.....	....	1	.0125
86 Miliaria.....	..	....	1	.018	1	.0125
87 Phlegmon.....	..	....	1	.018	1	.0125
88 Prurigo	1	.039	.....	....	1	.0125
89 Rhinoscleroma	1	.039	.....	....	1	.0125
90 Scarlatina	1	.039	.....	....	1	.0125
91 Strophulus pruriginosus....	..	....	1	.018	1	.0125
92 Syphilophobia.....	..	....	1	.018	1	.0125
93 Tylosis .....	..	....	1	.018	1	.0125
94 Varioloid .....	..	....	1	.018	1	.0125
95 Doubtful diagnosis.....	3	.12	9	.16	12	.15
	2,583	....	5,417	....	8,000	....

Ninety-four separate names of disease-states are found in the first table, and in the second table several of these are seen to be further subdivided, so that the total number of distinct eruptions here presented will number more than one hundred.

In regard to the nomenclature here employed, it may be mentioned that the aim has been to employ only well-known names, and to adhere to the rule of using a Latin terminology. For many years the cases have been recorded on a scheme of nomenclature and classification prepared by the writer for teaching, and the adoption of a definite and determined plan has aided much in securing records which, while made solely for practical utility in dealing with the cases, could be used in forming the present tables of statistics.

It will be observed that many affections appear less frequently than others; this, in many instances, is due to the comparative rarity of the eruption, while in other instances it is because the complaint is not such as would be

likely to be presented at a clinic for treatment. Thus, prurigo, rhinoscleroma, morphœa, scleroderma, and lepra, with other diseases, are very rare in this country, whereas the exanthemata seldom appear because of the nature of the statistics, which are drawn from special consulting practice, while minor affections, as pigmentary anomalies, and others are rarely presented on account of their trivial character. The patients were remarkably evenly divided in regard to sex—3,897 males to 4,103 females; very considerable differences, however, appear in regard to different affections. Thus, chloasma was observed almost exclusively in females, while the cases of sycosis all occurred in males, as this eruption belongs mainly to the bearded face. Acne was presented for treatment twice as frequently in females as in males, whereas double the number of males were seen for alopecia. In eczema, lichen, psoriasis, and syphilis the number of each sex was nearly the same. Other differences will be noted in connection with various eruptions.

The ages of the patients applying for treatment are shown in the next table, recording all the private cases and those occurring in public practice, with the exception of cases observed during the years 1874 and 1875, the records of which are not now accessible. The same restrictions apply also to subsequent tables: but Tables I and II include these years, as these general statistics had been already incorporated in the reports previously alluded to. It will be seen that the largest number of cases belonging to any period of five years is found in that from twenty to twenty-five years of age, the total then being 787; this is even greater than during the first five years of life, which gave 779 cases. This is not a little remarkable, considering the large number of individuals living between one and five years old, as compared to those living between twenty and twenty-five years of age, and also considering the delicacy of the infant's skin and the readiness with which it is supposed to be affected, as compared with that of adults. The least number of cases in any period of five years appears to be that between ten and fifteen years of age,—that is, considering the number of individuals living,—namely, only

TABLE III.

AGES OF PATIENTS WITH GENERAL SKIN DISEASES.

AGE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
6 months and under	29	21	50	48	51	99	149
6 months to 1 year	18	8	26	31	38	69	95
1 year to 2 years	18	13	31	71	65	136	167
2 years to 3 years	18	11	29	70	58	128	157
3 " " 4 "	10	9	19	42	46	88	107
4 " " 5 "	9	15	24	47	33	80	104
	102	77	179	309	291	600	779
5 years to 10 years	34	60	94	150	203	353	447
10 " " 15 "	19	52	71	105	190	295	366
15 " " 20 "	72	166	238	175	237	412	650
20 " " 25 "	120	224	344	266	177	443	787
25 " " 30 "	185	197	382	193	155	348	730
30 " " 35 "	182	122	304	151	110	261	505
35 " " 40 "	155	103	258	115	138	253	511
40 " " 45 "	129	83	212	82	91	173	385
45 " " 50 "	92	53	145	94	127	221	366
50 " " 55 "	69	40	109	64	78	142	251
55 " " 60 "	63	31	94	71	76	147	241
60 " " 65 "	39	27	66	40	24	64	130
65 " " 70 "	32	14	46	25	29	54	100
70 " " 75 "	20	9	29	7	7	14	43
75 " " 80 "	4	3	7	8	3	11	18
80 " " 85 "	1	2	3	3	3	6	9
85 " " 90 "	2	.....	2	.....	1	1	3
90 " " 95 " .....	.....	.....	.....	.....	.....	.....	.....
95 " " 100 " .....	.....	.....	.....	.....	1	1	1
Unknown age .....	.....	.....	.....	.....	1	1	1
	1,320	1,263	2,583	1,858	1,942	3,800	6,383

366, and the sudden increase between the ages of fifteen and twenty, to 650 cases, is not a little striking. This table may be advantageously studied in connection with those exhibiting the ages of patients with individual diseases, as we shall see later when speaking of the more common affections.

We may now pass to a brief consideration of some of the more important diseases, taking them up in the order of their relative frequency.

I. **Eczema.**—A glance at the tables will readily show that eczema holds the first place in point of frequency, as it certainly does in regard to the amount of distress occasioned. In Table II it is seen to form 33.99 per cent. of the private cases, and 33.24 per cent. of those seen in public practice, with a total of 33.48 per cent. in the entire 8,000 cases.

But this alone gives a very slight idea of its real frequency at different periods of life, which is by no means uniform. In the accompanying table (IV) are presented the ages of 2,500 patients with eczema, and from it may be

TABLE IV.
AGES OF 2,500 PATIENTS WITH ECZEMA.

AGE.	Males.	Females.	Total.
6 months and under	60	49	109
6 months to 1 year	43	39	82
1 year to 2 years	84	62	146
2 years to 3 "	67	62	129
3 " " 4 "	45	43	88
4 " " 5 "	28	32	60
Total infantile eczema	327	287	614
5 years to 10 years	99	117	216
10 " " 20 "	89	154	243
20 " " 30 "	177	162	339
30 " " 40 "	198	140	338
40 " " 50 "	154	158	312
50 " " 60 "	141	117	258
60 " " 70 "	79	56	135
70 " " 80 "	22	15	37
80 " " 90 "	2	3	5
90 " " 100 " . . . . .	....	1	1
Unknown age . . . . .	....	2	2
	1,288	1,212	2,500

judged the susceptibility of different years of life to the disease. A still more correct knowledge of the natural history of the affection may be obtained by a comparison of this table with the preceding, representing the general run of cases as they are presented for treatment. Thus we find that of the 779 cases of general skin affections occurring during the first five years of life, no less than 614, or almost 80 per cent. were cases of eczema; whereas in the next five years there were but 216 cases of eczema in a total of 447 miscellaneous skin cases, or less than 50 per cent. The average for this first decade of life gives 67 per cent. of all cases. In the next decade, that between ten and twenty years, 243 cases of eczema are found among 1,016 skin patients, or hardly 24 per cent.; still later, in the years between twenty and thirty, there were but 339 cases of eczema among 1,517 of all skin affections, or a little over 20

per cent.; in the following decade, that between thirty and forty, eczema formed over 30 per cent.; between forty and fifty, almost 40 per cent.; between fifty and sixty, over 52 per cent.; and between sixty and seventy years of age, almost 60 per cent. of all skin cases were those of eczema.

We thus see that during the earlier and later years of life the skin is most prone to take on eczematous action, while, as we will observe later, other affections belong rather to the period of early youth, others again to middle age, and still others to senility. The youngest patient treated with eczema was about ten days old, the oldest was said to be ninety years: between these ages almost every month was represented; there were forty-three patients with eczema who were seventy or more years of age.

In regard to sex, the patients were pretty evenly divided, 1,288 males to 1,212 females, although at different periods the proportion of each sex varied considerably. Thus in the decade between ten and twenty the females were almost double in number, owing probably in part to the influence of the development of the menses, whereas in the next decade the males were considerably in excess.

Little can be here said in regard to the phases of the eruption in these cases, or its location, but it can be readily understood that every conceivable form and variety of lesion is comprehended, from a single, hardened, localized, chronic patch of thickened skin, to a general, chronic, inflammatory eruption, involving a large area or the entire integument; or from a subacute, reddened surface, giving off a little moisture or scaling over, to an acutely inflamed, perhaps œdematous, exuding condition, affecting an extremity, the face, or much of the body. In regard to locality, every portion of the integument has been observed to be affected, from the crown to the sole.

With such a vast variety of manifestations, presenting all stages and conditions of inflammatory action, and located on different portions of the body, and on individuals with skins of various qualities, it is readily understood that very little can be said in a general way in regard to the treatment of the cases analyzed, or of the disease in general. Any

one who has had any amount of experience in managing eczema will appreciate the impossibility of indicating in the slightest degree a line of practice which will be serviceable in every case, or even in any proportion of those which may present themselves. The inutility and even harmfulness of prescriptions which sometimes are quoted as "good for eczema" must be apparent to any one who will give thought to the matter.

Suffice it to say in regard to the management of the cases here tabulated, that the treatment embraced the most varied means and measures suitable to the conditions present and to the individuals affected. Eczema, of all skin affections, is one, the conduct of whose treatment must be based on the broadest knowledge of medicine and the most judicious employment of remedies.¹

II. Acne.—The next most frequent affection in our list is acne, with a total of 973 cases, or 12.16 per cent. of the whole. The proportion of cases in private and public practice was quite different, it forming over 20 per cent. in the former, and only 8.33 per cent. among the poorer classes. This difference is undoubtedly in part caused by over-eating, sedentary habits, and other agencies which engender it among the rich, but also partly owing to the fact that the poor care less for the disfigurement of acne and have less time to devote to the removal of conditions which do not cause bodily suffering. Acne is probably much more common even than would be indicated by the figures here given, inasmuch as a very considerable proportion of individuals suffer from it to a greater or less degree during youth, or later, but the eruption is too often regarded not as a disease but rather as a necessary attendant of adolescence, or as a condition which cannot be relieved. The eruption is, in many young persons, a troublesome one to permanently remove, but great care can, in the large majority of instances, either cause the lesions to disappear or to be much diminished, and prolonged attention can very commonly ensure immunity from it. In the present study acne is used to in-

¹ For a full and practical study of the disease and its treatment, based on the cases here analyzed, the reader is referred to the recent work by the writer on "Eczema and its management," New York: G. P. Putnam's Sons, 1881.

clude all the affections of the sebaceous glands, both functional and inflammatory: in Table II the number of instances of each variety is indicated.

TABLE V.
AGES OF PATIENTS WITH ACNE.

AGE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
Under 15 years of age	4	15	19	5	35	40	59
15 years to 20 years	30	81	111	59	81	140	251
20 " " 25 " "	37	109	146	} 40	59	99	346
25 " " 30 " "	28	73	101				
30 " " 35 " "	12	32	44				
35 " " 40 " "	11	34	45	} over thirty years of age	40	63	206
40 " " 45 " "	8	17	25				
45 " " 50 " "	7	3	10				
50 " " 55 " "	6	5	11				
55 or more years of age	7	1	8				
	150	370	520	127	215	342	862

Table V exhibits the ages at which the acne was observed in all of the private cases, and those occurring in public practice during the last seven years. It will here be seen, as is well known, that acne is an affection of early life, occurring principally between the ages of fifteen and thirty years. It also shows, what is not generally recognized, that acne in some of its forms is also not uncommonly seen after thirty years of age, and may be met with even after the age of fifty: thus in private practice 143 out of the 520 cases, or almost 30 per cent., were thirty or more years of age.

In regard to sex the cases were very unevenly divided: of the 973 cases, 319 occurred in males to 654 in females, as shown in Table I. This disparity between the sexes was more marked among the private cases, where the males formed only 28 per cent. of the entire number. The causes are many which operate to cause a larger proportion of females than males to appear in these statistics. First, undoubtedly, must come the fact that men pay far less attention to such eruptions as do not cause them physical annoyance than do females, and this is shown in the fact that those males who do apply for relief are not nearly so faith-

ful in carrying out directions and persisting in treatment as are the females.

But my observations among patients and others have led me to believe that acne is far less common among males than among females, and a number of reasons for this can readily be found. The sedentary habits of females largely predispose to the sluggish circulation and the consequent dyspepsia and constipation and imperfect tissue-interchange which are at the bottom of very many cases; the greater disturbances of the system which occur at puberty and the menopause contribute also largely to the production of acne in females. As a local element, may be mentioned the greater tendency in females to make applications to the face, in the way of perfumes, powders, and cosmetics, which undoubtedly greatly tend to develop the eruption.

After the age of thirty it will be noticed that the proportion of males to females increases, and in private practice the numbers at this period are almost equal; a reason of this is found in the larger indulgence in fermented and distilled liquors, and in injury from abuse of tobacco, and the increase of dyspepsia, together with a lowered vitality from over-strain. These cases in later life are, as is known, mostly included under *acne rosacea*.

III. Syphilis.—The relative position of syphilis in a table exhibiting the frequency of disease will vary very much with the source from which the statistics are drawn. In the present instance syphilis is viewed in relation to its cutaneous manifestations, and the cases came under observation mostly because of skin symptoms, although at the New York Hospital, where a thousand and more of the cases were seen, the clinic includes venereal and skin diseases.

But syphilis may be looked upon from its dermatological aspect better than in connection with any other class of diseases, because it is very rarely the case that the patient entirely escapes skin symptoms, even if we exclude the primary lesion, whereas there is no other structure so universally affected. A purely venereal service would afford but very little real information in regard to the frequency of the disease in the way of comparison, whereas when the

skin becomes affected, many who had before been under treatment by druggists or by means of remedies obtained from friends, will seek relief from the skin lesions: further, the uncertainty attending the true nature of local sores early in their course would always give an element of uncertainty in purely venereal statistics.

The total percentage of syphilitic cases is seen to be 9.99, but the difference between the ratio in public and private practice, as shown in Table II, is striking; the disease occurring just twice as frequently in the former as in the latter, 5.93 per cent. in private, and 11.88 per cent. in public practice.

The ages at which the disease was observed are shown in Table VI. Thirty-seven cases are seen to have occurred

TABLE VI.
AGES OF PATIENTS WITH SYPHILIS.

AGE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
6 mos. and under .....	.....	2	2	7	7	14	16
6 mos. to 1 yr.	1	.....	1	2	6	8	9
1 yr. " 2 yrs. ....	.....	.....	.....	1	2	3	3
2 yrs. " 3 "	1	1	2	.....	1	1	3
3 " " 4 " ....	.....	.....	.....	.....	1	1	1
4 " " 5 " ....	.....	.....	.....	.....	1	1	1
	2	3	5	10	18	28	33
5 yrs. to 10 yrs. ....	.....	1	1	1	2	3	4
10 " " 15 " ....	.....	.....	.....	4	3	7	7
15 " " 20 "	2	3	5	30	19	49	54
20 " " 25 "	10	14	24	85	34	119	143
25 " " 30 "	13	12	25	53	30	83	108
30 " " 35 "	23	12	35	47	27	74	109
35 " " 40 "	15	6	21	25	28	53	74
40 " " 45 "	12	7	19	11	19	30	49
45 " " 50 "	7	.....	7	14	15	29	36
50 " " 55 "	4	.....	4	9	10	19	23
55 " " 60 "	3	2	5	5	6	11	16
60 " " 65 "	1	1	2	.....	1	1	3
65 " " 70 " ....	.....	.....	.....	.....	1	1	1
70 " " 75 " ....	.....	.....	.....	.....	2	2	2
	92	61	153	294	215	509	662

under the age of ten years, most if not all of them being inherited syphilis, and of these nearly one half were observed during the first six months of life. There were

none seen over sixty-five years of age in private practice ; but among the poorer classes there were two patients over seventy years of age who presented syphilitic symptoms. Nearly one half the cases occurred between the ages of twenty and thirty.

In regard to sex the patients were quite evenly divided, 436 males to 363 females. It is impossible to determine with certainty if men are more subject to the disease than women. There are certain reasons which would operate to cause a fewer number of females to apply for treatment ; prominent among these is shame, which often leads women to conceal even maladies which cause them great distress, when located on concealed portions of the body, or when supposed to be of venereal origin. The number of primary lesions presented for treatment in women is far less than those in men in every clinic with which I am acquainted ; and it is surprising, sometimes, to find how serious a lesion exists, primary or secondary, which has long been concealed by a woman. It must also be borne in mind that the initial lesions are frequently deeply seated, and often actually escape the knowledge of females. In women who are bearing children there sometimes seems to be an immunity from the skin lesions of syphilis, perhaps for a long period ; and frequently one will hear a married woman deny all skin lesions previous to a late tubercular or gummy manifestation. Among the children under five years of age there were nearly twice as many females as males.

IV. **Phthiriasis.**—The next skin affection which appears on the list, representing the diseased conditions of the skin caused by the presence of lice, can hardly be considered to occupy here its correct position, although the number of cases, 397, actually gave the next highest percentage, viz., 4.96. By reference to Table II it will be seen that the cases occurred principally among the lower classes, the proportion among private cases being less than half of one per cent. In a former analysis of the cases treated at Demilt Dispensary during 1876, phthiriasis composed twelve per cent. of the cases, standing second on the list in point of frequency. The number of cases could, of course, be greatly increased

if all the patients had been searched to discover the presence of lice. These cases refer to those who came for treatment on account of the itching and the lesions, which were found to be due to the presence of the parasite. Nearly two thirds of the patients were females, and in nearly two thirds of the cases the scalp was the portion infested; the long hair of girls and women, and the mode of dressing it, renders them peculiarly liable to this pest; pediculi were very rarely seen on the scalp of males. The single case of phthiriasis corporis seen in private practice was in the young daughter of a physician, who had just returned from a country boarding-place, and it could hardly be believed that the intense itching and the large masses of torn lesions could be due to so simple a cause; but the number of the pediculi present was very great.

Scabies, the other animal parasitic affection, which might properly be considered in this connection, will be seen to come fourteenth on the list, and will be mentioned in due order.

V. *Tinea*.—The vegetable parasitic eruptions constitute a large and important class of skin affections, coming fifth on the list, with a total of 360 cases, and forming four and one half per cent. of the whole. As will be seen in Table II, a number of quite different eruptions are included under the designation *tinea*, which are caused by three distinct parasites; these are, however, considered by some observers to be developments from one and the same fungus; we will consider, in turn, the lesions caused by them.

Tinea trichophytina, ringworm, or the eruption produced by the trichophyton tonsurans in different localities, is seen to constitute more than two thirds of the cases in this group; of these ringworm of the body formed nearly one half.

Tinea versicolor was observed 87 times, forming 1.08 per cent. of the whole; *tinea favosa*, or favus, occurred 31 times, making hardly .38 per cent., or less than one quarter the proportion occurring in Scotland.

The vegetable parasitic eruptions appeared in private and public practice in about the same proportion. In regard to

sexes, the number of males affected was almost double that of females.

VI. Psoriasis.—This eruption, which is generally believed to be very common, appears sixth on the list, with 333 cases, and a percentage of 4.16 of the entire number. The proportion in private practice was somewhat above that observed among the poor; this is probably owing to the greater attention paid to such eruptions by the upper classes, rather than to any greater frequency of the disease among them.

In regard to sex the cases were remarkably evenly divided, 169 males to 164 females. It is a little curious that in private practice the males should have been in excess by 23 cases, and in public practice the females in excess by 18 cases.

The following table exhibits the ages of most of the cases.

TABLE VII.

AGES OF PATIENTS WITH PSORIASIS.

AGE.	Private Cases.			Public Cases.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
Under 10 years	1	5	6	1	4	5	11
10 years to 20 years	3	15	16	15	24	39	55
20 " " 30 "	21	18	39	24	19	43	82
30 " " 40 "	28	10	38	15	16	31	69
40 " " 50 "	18	2	20	8	9	17	37
Over 50 years	6	6	12	6	11	17	29
	77	54	131	69	83	152	283

It is seen here that the eruption is rarely developed before ten years of age, in hardly 4 per cent. of all cases, and that it is comparatively seldom seen after fifty years of age. The youngest patients seen in private practice were two girls, not related to each other, each a little over five years of age; the eldest, a gentleman, aged seventy-two, with characteristic eruption on both elbows and some on the legs.

The largest number of cases was observed between the ages of twenty and thirty, although the number in the next

decade, thirty to forty, is large, considering the fewer persons living and the number of patients who neglect the treatment after a short trial. The age of greatest development is certainly after twenty, and the eruption seldom occurs for the first time after forty years of age.

It is to be understood that this table relates to the ages of patients at the time of applying for treatment, and not to the date of commencement of the eruption; in many instances the disease had lasted many years before coming under observation, and very rarely were cases seen within the first year of the appearance of the disease.

VII. **Urticaria.**—The true frequency of this eruption may not be indicated by its relative position as seventh in the list, and probably is not, for multitudes have more or less severe and transient attacks of urticaria without ever seeking medical relief of the same. The number of cases here occurring, namely, 199, or almost $2\frac{1}{2}$ per cent., represents in the main the more severe and chronic cases, some of which had often lasted for months or years.

The number of females was almost double that of the males; this is probably owing to the greater delicacy of the female skin, and to their general tendency toward neurotic affections.

The following table exhibits the ages of the patients:

TABLE VIII.

AGES OF PATIENTS WITH URTICARIA.

AGE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
10 years and under	1	2	3	18	16	34	37
10 " " to 20 years	1	4	5	9	14	23	28
20 " " 30 "	4	7	11	5	21	26	37
30 " " 40 "	1	3	4	9	6	15	19
40 " " 50 "	2	10	12	6	2	8	20
50 " " 60 "	3	2	5	1	4	5	10
Over 60 years	2	2	4	1	1	2	6
	14	30	44	49	64	113	157

No conclusions can be drawn from this table; the eruption seems to be almost equally frequent at all ages; it often

appears in very young children, and not very infrequently occurs in connection with eczema, or in eczema patients during intervals of freedom from the latter eruption.

VIII. **Ulcus.**—Ulcers are, in most instances, very properly regarded as secondary lesions, the result of some preceding pathological condition, and should ordinarily be grouped or classed in connection with the disease to which they belong; thus, the primary lesion of syphilis, the chancre, and also later ulcerative lesions are in this analysis placed among the cases of syphilis. Ulcers occurring in connection with lupus, leprosy, sarcoma, epithelioma, etc., are, of course, included under those affections and excluded here.

The present group is made to contain but two varieties of ulcer: the simple ulcer, from injury or defective circulation, especially exemplified in varicose ulcers of the leg; and also the venereal ulcer, caused by the entrance of the chancroidal virus. Of the former there were 131 cases, or 1.63 per cent. of all cases; and of the latter, fifty cases, or .62 per cent. The ulcers of the lower leg were largely seen in women who were obliged to be much upon the feet, and were frequently associated with more or less eczema.

IX. **Dermatitis.**—Here are classed 172 cases, or 2.15 per cent. of the entire number, and among them lesions presenting very different characters, and occurring under varied conditions. If all eruptions exhibiting dermatitis, or inflammation of the derma, were placed here, the number would be many times as great as here recorded. But the term has in late years been used to represent a local, self-limited inflammation of the skin produced by causes outside of the body; here again, however, the local irritation produced by animal and vegetable parasites are excluded, having received separate names. The somewhat new name, dermatitis medicamentosa, refers to eruptions produced by the internal administration of certain drugs, as quinine, copaiba, iodide of potassium, etc., of which some very striking cases were observed, which cannot be detailed here.

The cases of dermatitis were evenly divided between the sexes, eighty-six males to eighty-six females, as shown in Table I: the ages of the patients are shown in the following table.

TABLE IX.

AGES OF PATIENTS WITH DERMATITIS.

AGE.	Private Practice.			Public Practice.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
6 months and under	.....	.....	.....	.....	1	1	1
6 " " to 1 year	.....	.....	.....	.....	1	1	1
1 year to 2 years	.....	.....	.....	1	4	5	5
2 years " 3 "	.....	.....	.....	1	2	3	3
3 " " 4 "	.....	.....	.....	.....	2	2	2
4 " " 5 "	.....	.....	.....	1	.....	1	1
.....	.....	.....	.....	3	10	13	13
5 years to 10 years	.....	.....	.....	2	5	7	7
10 " " 15 "	1	1	2	1	7	8	10
15 " " 20 "	.....	2	2	3	4	7	9
20 " " 25 "	.....	2	3	4	1	5	8
25 " " 30 "	4	2	6	4	2	6	12
30 " " 35 "	4	1	5	4	6	10	15
35 " " 40 "	3	3	6	4	1	5	11
40 " " 45 "	4	1	5	.....	3	3	8
45 " " 50 "	1	1	2	3	1	4	6
50 " " 55 "	2	.....	2	1	2	3	5
55 " " 60 "	.....	1	2	5	.....	5	7
60 " " 65 "	1	.....	1	1	.....	1	2
65 " " 70 "	.....	.....	.....	1	1	2	2
	20	14	36	36	43	79	115

It will be seen that the cases were distributed throughout all ages, the skin being at all periods liable to inflame from external causes. It is often very difficult to determine at the outset between some cases of simple or poisoned dermatitis and eczema, and often an eruption which begins as a purely local dermatitis from a well-defined cause, as a burn, an injury, or the effect of poison, may, in a proper subject, develop later into a typical eczema.

X. Pruritus.—It is very important to clearly separate pruritus as a disease from pruritus occurring in connection with other skin affections; in the 152 cases, forming 1.9 per cent., itching was the only symptom complained of, and the lesions present were those caused by scratching, care being taken to eliminate cases where the itching was caused by parasites. There were twenty-two cases of pruritus senilis, and twenty-three cases of pruritus hiemalis; in many of the other cases the itching was about the genital region.

There were seventy-eight males and seventy-four females treated for pruritus.

XI. Furunculus.—Boils were seen twice as often among the poor as among the richer classes; the total number in public and private practice was 151 cases, or 1.89 per cent., of which seventy-three were males to seventy-eight females. These numbers do not include every one who chanced to have boils while under treatment, but only those who applied for the relief of such; very many of the eczema patients presented boils at some time during treatment.

XII. Lichen.—One hundred and forty-eight cases of lichen were recorded, constituting 1.85 per cent.; of these, 117 were of lichen simplex. Many writers would class these latter cases, or most of them, as papular eczema, and fail to recognize the acute and chronic forms of this eruption, giving the name lichen only to the last three varieties mentioned in Table II. Clinically, however, these cases differ from papular eczema in many particulars, which cannot be dwelt on here, and there is but little doubt that the papular eruption, long called lichen, exists, which, though related to eczema, maintains a separate entity. There were twenty-four cases of lichen planus, some of which resembled closely the lichen ruber of Hebra.

The cases were quite evenly divided between the sexes, seventy-two males to seventy-six females.

XIII. Erythema.—Of the 128 cases of erythema, 1.6 per cent. of all, sixty-one or nearly one half were of the variety known as erythema multiforme, and but thirteen of erythema nodosum. The cases of multiform erythema presented the most varying forms and degrees of the eruption; bullæ were occasionally seen, even of some size, especially in several private patients. The females were almost double the number of the males, eighty-five to forty-three, pointing toward a neurotic element; in a number of instances the eruption was seen in young female immigrants, just landed, where the confinement of shipboard, with its unusual food and bad hygienic conditions, had greatly deranged the system, and induced extensive skin inflammation.

XIV. Scabies.—This eruption, which in the statistics from Glasgow public practice exactly equalled eczema in frequency, forming more than one quarter of all cases,

stands here fourteenth on the list, with but 128 cases, or 1.6 per cent. of the whole. In private practice there were but ten cases, forming .39 per cent., while in Anderson's private practice in Glasgow it formed 4.4 per cent. The eruption is certainly becoming less frequent in this country as a knowledge of its true nature prevails, and hygiene and cleanliness are inculcated; the proportion of cases in the last few years' practice is much less than the figures above given would indicate. Often weeks or even months will go by without a case presenting itself, then a group of cases in a family, or school, or district will appear; careful treatment will cure these, and no more cases will appear for some time.

Of the cases here recorded, seventy-five were in males and fifty-three in females; but a single female was seen in private practice with scabies.

XV. Erysipelas.—This disease formed a trifle over one per cent., there being ninety-one cases, thirty-four males and fifty-seven females. Most of these were of a very mild type, generally about the head and face, and were treated as out-patients; many of them were about the nose and cheeks, and were more properly of the character which I have described as pseudo-erysipelas, occurring in connection with catarrhal difficulty and nasal ulcerations, and were rather local inflammatory conditions of the lymphatics than true erysipelas.

XVI. Alopecia.—Loss of hair is naturally a condition exciting more solicitude among the patients in private practice than among those in the lower walks of life, consequently we find more than three quarters of the cases belonging to the former class, namely, sixty-nine cases, forming 2.67 per cent. of all those seen in private practice. The total number of cases of alopecia seen was eighty-nine, forming 1.11 per cent. of the whole; of these the males were almost double the number of females, namely, fifty-nine to thirty.

Alopecia areata formed more than one half of all the cases, namely, forty-six; of these, fourteen occurred in public practice, and thirty-two in private practice, with a percentage of 1.24 of all private cases. The difference be-

tween the relative frequency of the disease in private practice with its percentage of 1.24, and in public practice with its percentage of .25, is not a little remarkable. The appearance presented by the smooth bald patches is so striking that it cannot escape attention, and the poor who are affected appear almost as solicitous about it as do the rich. The fact of its occurring, according to these statistics, almost five times as frequently among those in the higher classes as among those in the lower walks of life, points strongly toward the neurotic origin of the disease, and equally strongly away from its supposed parasitic origin. The following table exhibits the age and sex of patients with alopecia areata seen in private practice.

TABLE X.

AGES OF PATIENTS WITH ALOPECIA AREATA IN PRIVATE PRACTICE.

AGE.	Males.	Females.	Total.
10 years of age and under	- - -	3	3
10 years to 20 years of age	3	1	3
20 " 30 " " " " " " " " " " "	4	3	17
30 " 40 " " " " " " " " " " "	12	2	14
40 " 50 " " " " " " " " " " "	1	- - -	1
50 " 60 " " " " " " " " " " "	3	- - -	3
	26	9	35

From this it is seen that this peculiar affection is rarely seen in young life, only one sixth of the cases being twenty or less years of age; nor is it often seen after the age of forty. The youngest cases were in girls, aged respectively six, eight, and ten years; the oldest, a gentleman fifty-four years of age. The males were almost three times the number of the females.

XVII. *Zoster*.—Eighty-eight cases of herpes zoster were observed, giving a proportion of only a trifle over 1 per cent. This shows the disease to be less common than is usually supposed; the eruption is so startling, and often so painful, that those affected generally apply for relief, so that this percentage may be taken as a fair indication of its general frequency.

The accompanying table exhibits the ages of the cases.

TABLE XI.
AGES OF PATIENTS WITH ZOSTER.

AGE.	Private.			Dispensary.			Grand Totals.
	Males.	Females.	Total.	Males.	Females.	Total.	
10 years and under . . . . .	...	2	2	4	4	8	10
10 years to 15 years . . . . .	...	1	1	4	5	9	10
15 " " 20 " . . . . .	...	2	2	1	2	3	5
20 " " 25 " . . . . .	...	...	...	2	1	3	3
25 " " 30 "	2	2	4	1	1	2	6
30 " " 35 "	5	...	5	3	2	5	10
35 " " 40 "	1	1	2	1	1	2	4
40 " " 45 "	2	1	3	2	...	2	5
45 " " 50 "	2	...	2	...	2	2	4
50 " " 55 " . . . . .	...	...	...	...	1	1	1
55 " " 60 "	1	...	1	2	1	3	4
60 " " 65 " . . . . .	...	1	1	...	...	...	1
65 " " 70 "	1	1	2	...	2	2	4
81 years . . . . .	...	1	1	...	...	...	1
	14	12	26	20	22	42	68

It will be seen by this that the disease is met with at all ages; although it has always been thought to be very uncommon in young children, ten cases were seen in those ten years or less of age. The youngest patients in private practice were: a little girl of five years with a thoracic zona at the level of the seventh dorsal vertebra, possibly caused by irritation from vertebral caries very marked in that region; the other young patient was a girl of ten years, with a left lumbar zona, extending around into the groin. The oldest patient was a lady of eighty-one years, with an eruption on the left side of the neck, extending into the hair; the neuralgic pain of this was very great, but was completely relieved by a few applications from a galvanic battery.

In regard to sex the patients were exactly divided, an equal number of males and females.

XVIII. **Epithelioma.**—Next, in point of general frequency, comes epithelioma, with eighty-six cases and 1.08 per cent.; this, like several other diseases, occurred much more frequently in private than in public practice, it forming 1.74 per cent. of the former, and but .76 per cent. of the

latter. This apparent difference is probably owing to the greater anxiety with which those in the higher walks of life regard any thing which may in any way suggest a cancerous growth, rather than to any real predominance of the disease among the higher classes. Most of the cases presented the lesion upon the face, especially in the region of the nose; epithelioma of the lip was seldom seen, most of these cases going at once to the surgeon. There were fifty males and thirty-six females with epithelioma.

The ages of the private patients are exhibited in the following table.

TABLE XII.

AGES OF PATIENTS WITH EPITHELIOMA IN PRIVATE PRACTICE.

AGE.	Males.	Females.	Total.
Under 20 years of age . . . . .	...	1	1
30 years to 40 years of age	4	3	7
40 " " 50 " "	7	6	13
50 " " 60 " "	9	3	12
60 " " 70 " "	9	6	15
70 " " 80 " "	3	2	5
	32	21	53

As is known, the disease is rare in young life, but eight cases appearing in patients less than forty years of age; there was only one patient under thirty years of age, that being a colored woman nineteen years old, with epithelioma of the vulva.

XIX. Herpes.—The eruptions known as herpes (with the exception of herpes zoster, already considered) came next in frequency, with seventy cases, forming .87 per cent.; there were, forty males and thirty females with herpes. In twenty cases the genital region was affected, nineteen males and one female; the eruption is probably much more frequent in females than this would indicate, but shame very frequently prevents attention being given to such an eruption, which generally passes away quickly, without treatment.

XX. Lupus.—This disease is comparatively rare in this country, there being but sixty-nine cases among those ana-

lyzed, giving a percentage of only .86 in the whole number of cases. The cases were more common in private practice, where they formed 1.24 per cent. In other countries the disease is much more frequent; thus, in Glasgow, lupus formed 1.98 per cent. of McCall Anderson's public cases, and 2.5 per cent. in his private practice.

Of our sixty-nine cases, forty-two were of lupus erythematosus, and twenty-seven of lupus vulgaris: it is understood that tubercular syphilis, often known as syphilitic lupus, is excluded here, and reckoned among syphilitic cases.

Lupus is decidedly a disease belonging to the female sex; of these cases there were eighteen observed in males and fifty-one in females.

XXII. Chloasma.—This is another affection which is much more commonly seen in private than in public practice: of the forty-two cases, thirty-two occurred in private practice, forming 1.24 per cent. of all the cases. It is also almost wholly an eruption belonging to females: of the forty-two cases, but two were seen in males, both cases being in private practice, and well marked.

XXIII. Purpura.—There is little of interest in regard to the cases of purpura, except that from its relative position in this list the disease would appear to be much less frequent than might be commonly supposed, as it only formed .49 per cent. of all cases. It was seen with about equal frequency in private and public practice, and about as often in females as in males.

XXVI. Ichthyosis.—This affection was also observed much less frequently than might be expected, there being but twenty-eight cases, with a percentage of .35, of which the larger number were seen in private practice; it was seen seventeen times in males and eleven times in females.

XXVIII. Sycosis.—The cases here referred to relate to true, non-parasitic sycosis, a folliculitis or inflammatory condition in and around the hair follicles, principally occurring on the bearded face. This is quite distinct on the one hand from pustular eczema of the beard, and on the other from the vegetable parasitic eruption occurring in the beard, sometimes known as parasitic sycosis, or barber's itch; this

latter appears under its proper head, *tinea trichophytina*, which was spoken of fifth on the list.

There were twenty-seven cases of *sycosis*, all in males, forming .34 per cent. of the entire number of cases.

XXX. Nævus.—The actual frequency of *nævus* is not at all indicated by its position in this list, for comparatively few of those affected with any of the forms of "birth marks" ever seek medical or surgical relief; the popular superstition against the removal of these deformities is still very strong, as constantly appears when it is suggested to treat one which is casually found on a patient applying for some other difficulty. The cases which are brought for treatment are generally in children where the deformity is especially marked, or where a protruding or rapidly extending *nævus*, especially on the face or scalp, causes more than ordinary anxiety.

There were but twenty-six cases of *nævus* recorded, seven in males, and nineteen in females; of the whole number, sixteen were in private practice, giving .62 per cent., against .18 per cent. among the public cases.

XXXII. Varicella.—Chicken-pox is not very infrequently brought for treatment, under the supposition that it is some purely skin affection, and in slightly marked and also in very severe cases the diagnosis is often a little difficult. Twenty-one cases thus appeared, which, of course, in no way indicates the relative frequency of the disease, as the family physician is usually seen at once for such an eruption; the same is true of other exanthemata, and measles, scarlatina, and small-pox occur seldom in such statistics as those here presented.

XXXIII. Leucoderma.—This was mainly observed in private practice, where occurred seventeen out of the total twenty cases: those who are apt to resort to public clinics seldom pay attention to such pigmentary conditions, but from the comparative infrequency with which I have chanced to meet with it among those in the lower walks of life, both among patients and others, I am inclined to believe that it occurs much less frequently among them than among those who are more subject to nervous strain in the higher classes of society.

Of the twenty cases, eleven were in male and nine in female subjects. One very striking case was in a dark negro girl, in whom the process of whitening was occurring, the patches extending with considerable rapidity. They were scattered over various parts of the body, head, and limbs; and the shoulders, chest, and neck, which were large and finely formed, had every appearance of belonging to a white girl of fair skin.

XXXIV. Ecthyma and Impetigo.—Among the poor it is not very uncommon to find large pustular lesions, not belonging to other conditions, as, for instance, not due to scabies or syphilis, and not induced by pediculi or other recognizable cause: to these the names impetigo and ecthyma are given, although some recent authors, as Hebra, do not recognize these as independent affections. There were eighteen cases of ecthyma recorded, and thirteen of impetigo; the difference in the eruptions being mainly one of degree—the latter being more superficial pustules, the former more boil-like, but not having the central core.

Of the thirty-one cases, fifteen were in males and sixteen in females.

XXXVII. Pemphigus and Hydroa.—Excluding syphilitic forms of this eruption, seen mainly in children, and also, excluding the cases of multiform erythema in which sometimes quite large bullæ appear, true pemphigus is a rare affection in this country. But seventeen cases were recorded as pemphigus, and it is quite possible that some of these cases on further study might prove to be more properly classed as multiform erythema or other affections.

The term hydroa has been employed to designate irregular cases in which the bullæ are smaller than those commonly recognized as belonging to pemphigus, and which do not exhibit the features which could place them elsewhere. There were nine cases thus recorded. Of the total twenty-six cases thus exhibiting bullæ, twelve were in males and fourteen in females.

XLI. Keloid.—This curious neoplasm was recorded in but eleven cases, seven males and four females, but may be much more frequent than thus indicated, as casual cases

are occasionally met with, for which medical advice is never sought.

XLII. Xanthoma.—But ten cases of this condition were recorded, although the disease is relatively far more frequent than is indicated by this number, which makes only .12 per cent. of the whole: the milder forms occurring on the eyelids were occasionally noticed on patients with other affections, but not recorded in the notes. Of the ten cases, three were in males and seven in females.

XLV. Morphœa and Scleroderma.—These affections, which are closely allied, are rarely met with, they together forming only .15 per cent. of the whole number of cases. There were eight cases of morphœa, two males and six females; and four of scleroderma, one male and three females: this relation of the numbers in the sexes corresponds to that mentioned by other observers, who state both the diseases to be much more frequent in women than men.

L. Lepra.—Six cases of true leprosy, elephantiasis Græcorum, were recorded, four occurring in private practice and two among public cases; these were all in males. A number of other cases were seen at different times in hospitals and elsewhere, which were not recorded, as not belonging to the cases here analyzed. In two cases in private practice the patients were native-born Americans, and without discoverable heredity of the disease, and had never been five hundred miles from New York City. The origin in many cases was traced to residence in countries affected with the disease.

LX. Trichorexis nodosa.—Four instances of this peculiar condition were noted, all in males, in private practice; two were in physicians who also studied their cases very carefully. In all the patients the disease proved very rebellious.

LXXXVIII. Prurigo.—This eruption was recorded in but a single instance, and that in private practice, in a young lady, aged twenty-three years. The case was a very distressing one, and the patient finally died of glandular enlargements, which occurred in many parts of the body. No autopsy was obtained, but there was evidence during life of malignant disease of the lymphatic glands within the chest, which was the apparent cause of death.

LXXXIX. **Rhinoscleroma.**—A single case was recorded as rhinoscleroma, in the person of a young lady, twenty-seven years of age. The clinical features, the age of the patient, and the behavior of the disease after cauterization and cutting operations, all pointed strongly to the affection described by Hebra as rhinoscleroma, but after excision the growth resembled epithelioma microscopically in many of its elements.

In presenting the foregoing tables of statistics and the comments thereon, I have endeavored to add, in some measure, to the knowledge of the natural history of the various affections to which the skin is subject. The practical advantages to be derived from such presentations of facts are not always apparent at first sight, but it cannot be denied that every thing which contributes to knowledge will, in the end, in some way or other, be of service. The subject of diseases of the skin has been an obscure one in years which are past, and it is only within the memory of those now practicing medicine that much light has shined out of the darkness. Facts have rapidly accumulated in recent years, and much which was uncertain in dermatology is now well determined. It is hoped that the accompanying tables, which have cost much time and labor, will assist in determining the relative frequency of diseases of the skin, and their relations to age and sex.

The cases upon which the tables are based have been seen during the past twelve years, and the notes which have been taken of them to assist in their management, have not only served their purpose in that manner, but have afforded material for study, from which much knowledge can yet be drawn. The habit of careful note-taking cannot be too earnestly urged, especially among the younger members of the profession, who have the leisure in which to acquire the habit: not only do case records serve as aids to successful practice, but they are invaluable for the purpose of affording data from which alone disease can be studied in a scientific and satisfactory manner.

SOME NOTES ON THE HISTOLOGY OF LUPUS VULGARIS.

BY HENRY WILE, M.D.

THE histology of lupus tissue has been extensively studied by all the leading authorities, and as it is a peculiarity of the disease to appear in different forms, and thus present different microscopical appearances, it is no matter of surprise to find diversity of opinion regarding its histology. It is not my purpose to present a discussion on this subject, but rather a few original observations which I had occasion to make from a careful study of a typical specimen of the disease which came into my possession through the kindness of Dr. L. A. Duhring.

The following is a brief history of the case :

The specimen was taken from a woman 35 years of age. The disease was located upon the lobe of the left auricle, more on the posterior side, and in the form of a nodule about one half the size of an English walnut. It was of 25 years' standing, and at the time of the excision there was no ulceration, but the diseased part exhibited a somewhat exfoliated surface.

Microscopical examination showed that the disease was almost wholly confined to the corium, although on account of the character of the cells it was difficult in some places to see the precise limit between healthy and diseased tissue. Virchow (*Krankhaften Geschwülste*) says: "Lupus cells resemble very much those of the rete Malpighii, so that it is often difficult to define clearly the boundary between the rete and the lupus tissue." This is nothing unusual, as we

often find pathological processes with irregular obscure boundaries, which here and there shade off into the surrounding normal tissue. A further illustration of this was seen in the fact that even the horny layer of the epidermis was in one place very much encroached upon by the lupus new-formation.

The cell of lupus is distinctly lymphoid in character, and a most important feature of this specimen was the nodular arrangement, resembling very closely submiliary tubercles. Upon this appearance Friedländer bases his hypothesis that lupus is a local tuberculosis of the skin. This aggregation of cells was noticed in all the sections and was confined to the corium. It is a well-known appearance, and is described by authorities as characteristic. Kaposi (*Pathologie et Therapie der Hautkrankheiten*, p. 627, Wien, 1880) describes these aggregations as "smaller or larger, roundish, nest-like arrangements scattered in the corium." He calls them "lupus nodes."

Besides these nodes, giant cells measuring $\frac{1}{300}$ to $\frac{1}{200}$ inch in diameter were seen, which were for the most part situated in the peripheral portions of the infiltration, *i. e.*, nearest the surface. Some of them appeared as large granular bodies, roundish and oval in shape, with nuclei situated only peripherally, while others showed prolongations, with the nuclei more uniformly scattered throughout the cell. Kaposi (*Vierteljr. für Syphilis et Derm.*, 1879) says that in most cases the nuclei are situated superficially and on the edge of the cell, and that this appearance may be due to the cells becoming opaque, so that only the superficial nuclei can be seen, while those within are hidden from view.

Some of the giant cells were surrounded by a transparent space in which no cells were seen, while the majority were found embedded in a dense mass of lymphoid cells. These cells are variously regarded by the different authorities.

Thin (*Med.-Chirurg. Trans.*, vol. lxii, 1879) regards them as diseased blood-vessels. Kaposi (*Vierteljr. für Dermat. u. Syph.*, 1879) says they are due to a "fusion of cells taking place during a retrograde metamorphosis, as they are found

in greatest numbers where the retrograde change begins, *i. e.*, in the centre of the lupus mass." Their genesis is still a subject of dispute, and what has been hitherto offered upon this theme is theoretical, and will not bear the test of histological analysis. Yet their presence is a fact, and their situation, together with other facts to be mentioned, has, I think, some bearing upon the direction in which the diseased process extends.

According to the view of Kaposi, above stated, the centre of retrograde change in this case must have been situated at the periphery, for it was there that most of the giant cells were found. But this was not so. The papillary layer of the corium was in some places observed to be intact, and the surrounding tissue, though involved, failed to reveal any sign of retrograde metamorphosis. On the contrary, it was a picture of active cell-life. Kaposi, however, claims, further, that these multinuclear masses are found in combination with other forms of degeneration, and are "the expression of retrograde metamorphosis." They are likewise found where the processes are active, being often seen where active processes of granulation are being carried on, such as in the bed of healing ulcers.

Birch-Hirschfeld (*Patholog. Anat.*, Leipzig, 1877, p. 90) says: "Giant cells are often found in fungus granulations (caroluxurians)," or, as Rindfleisch (*Patholog. Gewebslehre*, 1878, § 98) calls it, "hyperplasia of granulation," which may be regarded as a prototype of progressive tissue-change. Giant cells are found in embryonal marrow of bone physiologically, and pathologically in those sarcomas which take their origin from the marrow of bone, and often attain an immense size. Thus giant cells can with equal justice be regarded as "the expression of active cell-proliferation." Regarding them in this latter light, I would infer that their location indicated a comparatively recent extension of the process, and that the diseased action had extended from below upward, from the deeper layers of the corium first. But there are still other facts.

A careful examination showed that the structure was quite vascular, especially at the periphery, less so in the

deeper portions. Some authorities, as Jarisch (*Vierteljahrsschrift. für Derm. et Syph.*, vii, 1880), claim that in lupus there is a marked increase in the number of blood-vessels. The above-mentioned author further explains the formation of nodes by this increase in the number of blood-vessels, which causes a swelling and division of the connective tissue, thus aggregating the cells which happen to lie in the meshes.

In regard to the character and distribution of blood-vessels I observed the following: Those in the deeper or lower layers of the corium were comparatively few in number, and in some the adventitia had undergone a marked thickening. Proceeding toward the periphery it was observed that the blood-vessels grew more numerous and presented a more normal appearance than those more deeply situated. They were for the most part empty, but around about them was noticed a concentric arrangement of lymphoid cells, and there was one vessel which contained a complete lining of cells, but the centre of the lumen was empty.

A few vessels were seen lined with an irregular fringe of lymphoid cells, which were peculiarly arranged,—not circularly, but in rows longitudinally along the wall of the vessel, for where a blood-vessel had been cut obliquely, and a portion of the endothelial wall was presented to view, straight rows of cells could be seen, not unlike the rows in the interfibrillar spaces. This fringe or lining was of unequal thickness in the different vessels, and presented in most places a ragged appearance. The origin of these cells, together with their peculiar arrangement, is a question, yet the appearances taken together are very remarkable, and especially interesting and important in connection with the genesis of lupus tissue, as the most recent literature on the subject shows. Kaposi says (*Pathologie et Therapie der Hautkrankheiten*, Wien, 1880, p. 627): “When lupus tissue was supposed to spring from the connective tissue only, whether from the upper layer of the corium (Virchow, Billroth), whether from the hair follicle, or sebaceous gland (Veiel, Rindfleisch), it was also strenuously advocated that

it originated from the blood-vessels. According to the tendency of recent histological investigation the blood-vessels play an important part in the genesis of this pathological tissue (Lang, Stilling, Jarisch)."

The blood-vessels directly under the rete were observed to have thin walls, as though newly formed, and were surrounded by dense masses of lymphoid cells.

This observation in regard to the character of the blood-vessels, viz.: that those in the deep layers of the corium had thickened walls, those in the more superficial layers presented a more normal appearance, while those directly under the rete were more embryonic, would also seem to indicate that the process had extended from below upward.

Below the mucous layer were seen large concentric bodies measuring between $\frac{1}{20}$ and $\frac{1}{40}$ of an inch in diameter. Careful examination showed them to be composed of layers of fused flat cells, which happened to be cut in such a way that their outlines could hardly be traced. These layers were lamellated concentrically, and on account of the direction of the cut, represented mere lines, not unlike fibrous tissue. The centre of some of these bodies had undergone a retrograde change, destroying to a great extent the concentric arrangement. They resembled one another very closely, yet exhibited appearances which revealed different stages of development. They were of various sizes, and, what was very apparent, the larger ones were more loose in their structural arrangement, and were only connected with the surrounding tissue by means of some loose fibrous bands. The smaller ones were more compact in their structure, exhibited no signs of degeneration, and were closely adherent to the surrounding tissue. There were no other particular features, except that between some of the layers few round cells and some granular matter could be seen.

These bodies cannot be compared to pearly bodies, as they presented striking differences in size, composition, course of development, and general appearances. Their origin, judging from their location, was from the sebaceous

glands. Several of these bodies were seen, in subsequent sections, in corresponding locations, and in three sections there were round empty spaces from which similar bodies must have fallen out during the process of cutting and mounting. They seem to have replaced the sebaceous glands, and, by comparison, this peculiar metamorphosis of the glands could be traced. For in the immediate vicinity of one of the bodies described above, there was to be seen a markedly prolonged indentation of the mucous layer of the epidermis, in the centre of which prolongation was a small oval body containing a round nucleus. The peripheral parts presented the appearance of concentrically arranged lamellated fibres, while the nucleus seemed to be a more compact granulated mass, and did not take the staining well. This marked prolongation of the epidermis seemed to me to be nothing else than a hair follicle containing an atrophied hair. The section was cut almost perpendicular to the skin, and in such a direction that the sebaceous gland seemed to lie on the hair follicle. Thus this peculiar oval body seemed to lie in the hair follicle, but really was situated in the sebaceous gland, a part of which could plainly be seen immediately below. Wigglesworth (*Virginia Med. Monthly*, April, 1879), in a description of some specimens of lupus erythematosus makes this statement: "Here and there were round spaces, or alveoli, with a wall composed of fine fibres. These spaces existed in the corium, a few, however, being in the epidermis, some even bursting on the free surface, probably representing milia, arising, as shown by Neumann, from destruction of a hair follicle or the lobule of a sebaceous gland." The spaces which I found may correspond with those mentioned by Wigglesworth, and the peculiar bodies described above may be the ones filling those spaces.

The subcutaneous connective tissue presented a very striking appearance. It was infiltrated with small round lymphoid cells,—the infiltration invading the interfibrillar spaces, so that the fibres being seen longitudinally, the interfibrillar spaces presented a beautiful arrangement of bead-like rows, running parallel with one another. Here and there clusters of fat-globules were also seen.

NOTE ON THE TREATMENT OF ERYSIPELAS.

BY HENRY G. PIFFARD, M.D., NEW YORK.

THE methods of treatment mostly in vogue may be briefly summed up by the mention of the drugs chiefly relied on. These are: Large doses of quinine given as an apyretic, with or without opium; large doses of salicylic acid as an apyretic and anti-zymotic; large doses of chloride of iron for some supposed specific influence on the disease; carbolic acid as an anti-zymotic, by the mouth or hypodermically; together with local treatment, which may consist in simple cooling lotions, as the ordinary lead and opium wash, or Higginbottom's nitrate of silver application, or circumscribing the seat of disease with the tincture of iodine, etc.

Some years since, in looking over the back volumes of the *Lancet*, I was attracted by the report of some cases of erysipelas treated by the eminent English surgeon, the late Mr. Liston. He advocated the use of aconite and belladonna (*Lancet*, April 16, 1836) as preferable to any of the other methods with which he was acquainted.

A few months after reading Mr. Liston's statements, I had an opportunity of trying his plan, and from that time to the present, the drugs mentioned have been with me the main-stays of treatment, both in the idiopathic and traumatic forms.

The following cases illustrate the main points in the method that I advocate.

CASE I.—Mr. A. B., a gentleman 37 years of age, contracted syphilis fifteen years ago, and was treated by me for tertiary mani-

festations of the disease in November and December, 1880. He has been a hard drinker for years, and has had several attacks of idiopathic facial erysipelas, each of which confined him to the house from two to three weeks. On January 28th of the present year, he sent an urgent request to call at his house. I visited him about ten o'clock in the morning, and found that he was suffering from another attack of facial erysipelas that had commenced the day before, while *en route* from the South to this city. The trouble had commenced on the nose, spread over the cheeks, mounted to the forehead, and was progressing toward the scalp.

The temperature was 102.2° F.; pulse 130, and full; tongue furred, skin dry, no appetite; headache and some prostration. Ordered tincture of aconite root, to be repeated every hour until moisture appeared on the skin, then every two hours until evening. The inflamed integument to be thoroughly coated with a mixture of equal parts of unguentum belladonnæ, and unguentum simplex. No food to be taken during the day, but lemonade or carbonic acid water *ad libitum*. I saw him again at nine o'clock in the evening. The erysipelas was stationary, and his general condition improved, as follows: Skin moist, temperature 99.4° , pulse 100; and wants to eat; in addition, pupils widely dilated, vision impaired, and throat dry. He feared that the erysipelas was leaving his face and going to his throat and eyes. Assured that it was the belladonna and not erysipelas affecting these parts, he was ordered to take two doses of aconite during the night, and was permitted to eat a bowl of gruel, and to repeat it for breakfast if he felt inclined. On the following morning to take a dose of aconite if feverish, but if pulse below 90, to take instead, two grains of quinine, and repeat at noon.

Jan. 29th.—Saw him at 2 P. M., and found fever about gone (forgot to carry thermometer), pulse 85, tongue cleaner than the day before, tumefaction of the skin less, feeling in every way better, except as regards his throat and eyes. Ordered to discontinue the aconite definitely, to use less belladonna, and to continue the quinine two grains three times a day, and to have a more liberal diet.

Jan. 30th.—Erysipelas almost gone; discontinue belladonna, continue quinine, and resume usual diet.

Jan. 31st.—Last visit, patient practically well, may leave his house and attend to business to-morrow.

CASE 2.—Patient called at the office with a felon on second finger

of right hand. The trouble had commenced five days previously, and the parts had been poulticed continually. On examination, found finger swollen, painful, and fluctuating; palm swollen and painful; back of hand swollen, reddened, and pitting on pressure; red streaks running up the arm, and axillary glands tender. Slight fever, tongue coated, no appetite, little sleep for several nights. Treatment: Opened the felon, and continued the poultice. The next day the finger and palm were in much better condition, but the erysipelato-cellulitis of the back of the hand appeared to be increasing. Ordered aconite, three doses per day, and belladonna ointment to be thickly spread over the back of the hand, and the entire member to be wrapped in cotton-wool confined by a flannel roller. On the third day the back of the hand was less swollen, the redness replaced by a brownish hue from the belladonna, and the general condition improved. The eyes and throat gave evidence that the belladonna had been absorbed by the system. Discontinue the aconite, and take two grains of quinine three times daily. From that time on, the case progressed favorably and made a good recovery.

I select these two cases as they represent both the medical and surgical aspects of erysipelas, and both show immediate amendment as soon as the patient is fairly under the influence of the drugs. It will be noted that the aconite is given in doses sufficient to produce defervescence, and the belladonna until the constitutional symptoms produced by the drug are apparent. The aconite is discontinued when the fever subsides, and the belladonna diminished as the local condition improves. The quinine is given, not as an apyretic, in fact not until the febrile action has subsided, and then in but moderate doses. Since adopting this method of treatment, it has been my fortune to meet with cases in the early stages only, and in these I confidently recommend it.

References to the experience of Fleming, Thompson, Trousseau, Phillips, Bartholow and Köhler in the use of aconite and belladonna in erysipelas will be found on page 179 of my "*Materia Medica and Therapeutics of the Skin.*"

Clinical Reports.

CLINICAL ILLUSTRATIONS OF DISEASES OF THE SKIN.*

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CRIPPLED, ETC.

XI. Acne.—The functional derangements of the sebaceous glands, and also the simple inflammatory affection common in young people, acne simplex, have been treated of in former articles. There remain yet two forms of sebaceous disease, characterized by inflammation, to be considered, namely acne indurata and acne rosacea. As remarked in a preceding article, the different varieties of disturbance of the sebaceous glands are commonly found commingled, and rarely do we see one form existing alone from first to last. The inflammatory conditions are continually found to be accompanied by the functional disturbances of seborrhœa and comedo.

ACNE INDURATA.—The eruption in this phase of sebaceous disease is characterized by the presence of masses of inflamed

* The very favorable reception which was accorded to the "Notes on the Local Treatment of Certain Diseases of the Skin," until most of the diseases which are at all common were gone over, in previous issues of these ARCHIVES, leads the editor to continue this plan of serial writing for general practitioners in the form of "Clinical Illustrations of Diseases of the Skin." It is intended in these to give plain and practical comments on dermatological subjects, based on illustrative cases taken from private and public practice, some of the matter at times being that delivered in clinical lectures at the New York Hospital. The diseases will, as far as practicable, be treated of in the order in which they occur in the classification commonly found at the beginning of the Digest Department. These notes are continued from pages 60, 139, 261, and 399, volume vi; from pages 162, 301, and 403, volume vii; and from pages 29, 130, and 232, volume viii.

tissue of varying size, often as large as a good-sized pea, which may present a pustular summit, but which generally require to be lanced before pus is discovered. They are frequently very indolent, purplish in color, lasting weeks or months, commonly leaving somewhat of a permanent scar, and often partake rather of the characteristics of dermic abscesses than of those of the lesions of acne simplex. They may be quite painless on pressure, and the contents are found to be bloody and sometimes fetid. There are frequently present more or less of the elements of the rosaceous acne, next to be described, and comedones are generally to be seen. The skin usually presents an inactive, doughy condition, and the patient often exhibits other marks which are commonly called strumous.

The following history represents well the average case of acne indurata in a mild form.

Mrs. H., aged twenty-nine, first consulted me January 11, 1882. She was in fair general condition, the mother of three healthy children. Since fifteen or sixteen years of age she had had an eruption of acne, worse during the week before the appearance of the menses, and the lesions, which were small at first, had in late years formed indurated masses of various dimensions, up to that of a good-sized pea. The inflamed points were exceedingly indolent, often remaining for many weeks, and seldom discharging unless opened, and generally left scars.

When first seen the cheeks and chin were thickly sprinkled with nodules of various sizes, with a few comedones and many cicatrices, some of them still reddened, many quite pale. The lumps were of a purplish color and very sluggish, giving little or no pain on pressure and exhibiting no pus until lanced. She was of light complexion and hair, and the whole skin was of a rather thick, doughy character. The following mixture was prescribed: \mathcal{R} Potass. acetatis, \mathfrak{z} i; tincturæ nucis vom., \mathfrak{z} ii; extr. rumicis rad. fl., \mathfrak{z} iv. \mathfrak{M} . Take a teaspoonful half an hour before eating, in considerable water. She was also directed to bathe the face at bedtime for two or three minutes with very hot water, and afterward to apply the following lotion freely, using it also during the day, but without the hot water: \mathcal{R} Potassii sulphuret., zinci sulphatis, $\overline{\text{aa}}$ \mathfrak{z} i; aquæ rosæ, \mathfrak{z} iv. \mathfrak{M} .

Three weeks later, February 2d, it was noted that there had been very considerable improvement in the condition of the face; new lumps had ceased to form, some of the older ones had come to the surface and exhibited pustular summits, and the entire complexion appeared much clearer. The face was that day freely scarified, each lump and pustule being penetrated with a lancet, and considerable pus was evacuated; the incisions were encouraged to bleed by bathing in tepid water, and the same treatment contin-

ued, with the addition of two grains of the bisulphate of quinine after each meal.

Nine days later, February 11th, it was recorded that there was decided improvement; most of the old lumps had disappeared, but as some new small pustules were appearing she was given sulphide of calcium in quarter-grain doses four times daily. Two more scarifications were found to be necessary, owing to the deep-seated masses, a few of which remained for some time. Two months later the face was apparently well, with almost no trace of the former eruption, except the cicatrices which had formed before the commencement of the treatment; the incisions had left no marks, and the lumps thus treated had caused no scars, except a slight staining, which was fast passing away. During the preceding month she had been taking an iron, bark, and arsenic mixture, with occasional use of alkalies.

One month later she remained free from her eruption, with the exception of a few acutely formed pustules, which came and went rapidly after indiscretions in diet. When last seen, in July, the face was entirely natural in appearance, with no traces of eruption.

All cases do not yield as satisfactorily as the preceding, and in the next one it seemed impossible to make more than a temporary gain, owing to constitutional conditions, and circumstances which operated adversely.

Mrs. T., from Tennessee, was referred to me, March 11, 1879, for the treatment of a very extensive acne indurata, which caused great disfigurement. She was a rather delicate lady, thirty years of age, with dark hair and eyes, the mother of two children. She had never enjoyed good health, although never having had any severe illnesses. Her digestion had been bad for many years, she being greatly afflicted with heartburn, following the use of almost every article of food. Some time ago she had been subject to diarrhœa, but of late years was very constipated. The urine was very apt to be thick, and she constantly rose at night to pass water. Her menses were almost always delayed, were very scanty and exceedingly painful, and she was always troubled with leucorrhœa; the cervix was reported to be large and ulcerated, with a slight laceration, and the uterus was fixed. She would not consent to an operation for the relief of her uterine difficulties, although she suffered greatly from them, with severe and almost constant pain in the back after very moderate walking.

Her eruption had lasted nearly eight years, beginning two years before marriage, developing first upon the left side of the chin. She had never been entirely free from it, although the lesions had almost disappeared during the preceding summer while at a mineral spring; but the subsequent attack had been the worst she had ever had. She was found to be in poor general condi-

tion, with constipated bowels, suffering from indigestion, with a moderately coated tongue and a capricious appetite. She had not restricted herself in diet, but ate much hot bread and cakes, and was very fond of sweets. The pulse was 88, and of fair strength.

On examination almost the whole face was the seat of an eruption, composed of indurated, purplish-red masses of various sizes, with some pustules and considerable intermediate redness, but no comedones. The nose was especially badly affected, and caused much distress.

She was put upon a carefully restricted diet; moderate and gradually increasing exercise was enjoined; and a pill of aloes and iron prescribed, to be taken after each meal. Locally, she was to soak the face with hot water every evening for two minutes, with a handkerchief, and subsequently to apply the following lotion, which was also to be dampened on during the day: \mathcal{R} Sulphuris precip. 3i; etheris sulphurici, 3iv; spiritus vini rectific., 3iiss. \mathcal{M} . Four days later she was given a mixture of acetate of potassa, nux vomica, and quassia.

Nine days after the first visit very considerable improvement was recorded; the masses of inflammation were smaller and less marked, and small points of suppuration appeared, indicating activity in the process. The face was then freely lanced twice, at intervals of a week, and the bleeding encouraged by bathing with tepid water.

One week after the last operation it was noted that most of the redness was gone, and that very few of the lumps remained. She had improved much in health and general condition, having been taking the aloes and iron pill latterly but once daily. She had also received a mixture of acetate of potassa, nux vomica, and rumex, similar to that prescribed in the previous case, and latterly in its place sulphide of calcium, one quarter grain four times daily. The local treatment was continued the same, the wash first given serving to moderate the inflammatory condition very materially.

Shortly after this she returned to her home in Tennessee, and almost immediately the dyspepsia returned, and with it the face again exhibited a few hard papules; the trouble then increased, until one month later there was a very considerable amount of eruption, which caused her much distress. She had also become worse in regard to her uterine symptoms, which had largely disappeared before she left New York; at this time she could not walk at all, and standing five minutes gave great pain in the back. She had been given the compound tincture of green soap to stimulate absorption of the remaining lumps, after the acute symptoms of the eruption had subsided; this had proved very beneficial and served to drive away single points as they appeared, but soon all treatment lost effect while she was at her home, and a considerable amount of eruption developed.

During this summer she went to the Montgomery White Sul-

phur Springs of Virginia, and was much benefited, the skin becoming quite clear and the general circulation much improved. But soon after her return to her home she again had indigestion and her eruption reappeared, all medicines seeming to disagree with her.

She came again to New York in December of the same year, and received a certain amount of treatment for the uterine difficulty, but was never operated on for the laceration of the cervix. Her dyspepsia was largely removed by treatment, and her face became almost free from eruption; the compound tincture of green soap now served to drive away very promptly any single points which appeared.

In January she returned to her home and again became worse in every particular, the face looking and feeling worse than for months; this continued with much dyspepsia, despite of care and the use of many remedies.

The following summer she went to Mont Vale Springs in Tennessee, using the chalybeate water, and had very much dyspepsia, and the face was once more in a very bad state. After her return home, however, she improved in every way, the dyspepsia ceasing, and when she came next to New York, in December, 1880, the face was looking very well, with but a few small indurated spots on the right side of the face and chin. Her general condition was better than at any time during her treatment, although she still had occasional attacks of acidity, and the uterine disease still gave trouble if she walked; there was also some bladder irritation which had existed off and on for several years.

In this case there could be little doubt but that the acne was closely dependent upon the state of the digestive organs, which again was closely connected with the condition existing in and about the uterus. How far the dyspeptic state depended upon irritation reflected from the sexual organs cannot be stated, or how far the uterine engorgement was kept up by portal congestion cannot be determined. It seems very probable that if she would have submitted to a radical operation for the relief of the uterine disease, much more permanent gain could have been obtained in the management of the digestive state and the skin disorder.

In some cases the skin lesions take more the form of cutaneous abscesses, and the disfigurement caused thereby is often very great. In the following case the extent and severity of the eruption can hardly be understood from any description, and the change in appearance accomplished by a few months of treatment was indeed more than could have been expected.

Miss E., aged thirteen, was brought to me from New Jersey, March 15, 1882, with as greatly disfigured a face as one often

sees from acne. The eruption had first appeared two years previously, on the cheeks, forehead, and chin, and had gradually increased in extent and severity until the time of the visit. She had been treated continuously almost since its appearance, first by a physician of prominence in Easton for nine months, and latterly by a homœopathic physician for fourteen months; all previous measures seem to have had little effect on the disease.

She was found to be a fairly developed girl, with medium dark hair and eyes, and a doughy skin. Her health was said to have been good for the preceding six months, previous to which time she had suffered greatly from nervous headaches. The pulse was 120 and weak, the hands and feet were always very cold, and the tongue moderately coated. The digestion was claimed to be good, she being careful in diet; the bowels acted daily, and the menses, which had begun a year previously, were regular and normal, lasting five days, and without pain.

The eruption, which had commenced a year before the appearance of the menses, was found to occupy the whole face, cheeks, forehead, and chin. The surface was largely covered with the various forms of the lesions, papules, pustules, indurated masses, and several rather large abscesses. On the right cheek was an indolent abscess, half an inch in long diameter, purplish, flat, painless, and presenting distinct fluctuation just beneath a rather thin covering; on the left cheek were the remains of a similar lesion, which had recently discharged pus. There were also a number of other smaller abscesses, of a similar cold nature. She was given a lotion of sulphuret of potash and zinc, similar to that employed in the first case, was directed in the use of very hot water locally, and was given the following medicine: \mathcal{R} Magnesii sulphatis, \mathfrak{z} vi; ferri sulphatis, \mathfrak{z} i; acidi sulphurici dil., \mathfrak{z} ij; syrapi pruni virg., \mathfrak{z} i; aquæ, \mathfrak{z} iij. \mathfrak{m} . One teaspoonful in water, through a tube, after eating.

Sixteen days later the improvement was marked; the eruption was much paled, though there were still some indurated lumps and some redness. The pulse was 84, the tongue a little white, and she looked decidedly better in general appearance; the treatment was continued unchanged, except by the addition of a little more iron and magnesia to the medicine.

The improvement was continued, but as the redness of the cheeks remained, she was given, three weeks later, a mixture of acetate of potassa, nux vomica, and rumex extract. On May 31 it was recorded that the improvement was very marked, the redness had largely gone, and very few of the lumps remained. The last mixture was continued morning and night, and a tonic of iron, bark, and arsenic given after meals.

When last seen, Sept. 27th, the face appeared quite normal, with hardly any stains even of the former eruption. She was still, however, not in full health, but was easily tired, and the menses were somewhat delayed.

This case was peculiar in many respects : the eruption was unusually severe for so young a person ; it appeared a year before the occurrence of the menses, and was not apparently connected with any recognizable disorder of the digestive or sexual organs. The ease and rapidity with which it yielded to treatment were also a little remarkable.

In some cases the indurated acne depends largely, if not solely, on indulgence in alcoholics or beer, and not infrequently is quite incurable while they are taken even in moderation.

Mr. John —, aged thirty-three, a lawyer, first consulted me June 21, 1871, for an eruption which almost unfitted him for the practice of his profession. He was of full habit, had light hair and eyes, and claimed that he had enjoyed fair health. For some time he had had pain in the region of the stomach before and after eating, passing wind by the mouth and anus, and for a few weeks previous to his visit had had occasional attacks of vomiting without known cause. Since boyhood, he said, he had had "flesh-worms."

When first seen the face was greatly disfigured by masses of red, inflammatory tubercles, some with suppurating summits, which, with the intervening redness, covered almost the entire surface, giving it a very striking appearance ; the skin was also very greasy, and many comedones of large size were seen. Between the actively-inflamed and angry-looking lumps were numerous cicatrices, resulting from former lesions of the same nature. The face had been similarly affected during the preceding summer, but the eruption disappeared during the following winter. His sister, who was much confined as a principal in a public school, was similarly affected, but to a less degree ; she has since been under my care.

He was cautioned in regard to diet, and alcoholics were entirely interdicted, especially ale, which he took more or less freely. He was given a pill of blue mass, colocynth, and ipecac, to be followed by Kissingen water in the morning, and the following medicine was directed to be taken in teaspoonful doses, well diluted, between meals : \mathcal{R} Potassii acetatis, \mathfrak{z} i ; spiritus mindereri, \mathfrak{z} i ; spiritus etheris nitrosi, \mathfrak{z} ss ; extracti taraxaci fl., \mathfrak{z} iiss. \mathcal{M} . Locally, he was directed to bathe the face with very hot water at night, and afterward to apply the following lotion, using it also in the morning : \mathcal{R} Liquoris potassæ, \mathfrak{z} i ; aquæ, \mathfrak{z} ij. \mathcal{M} . Ft. lotio.

One week later the face was in a much better condition ; many of the pustules had discharged considerable pus, and were drying up, the whole face having a much less congested appearance. He was directed to take Kissingen water every other morning, and was given a mixture containing a little arsenic with the alkali.

He was not seen again until the following October ; the face had gotten very much better under treatment, which was then dis-

continued, and he had indulged pretty freely in stimulants, the breath smelling then very strongly of them. The face had again become greatly affected, looking as badly as at first, with large masses of inflamed tissue. He was placed back upon the treatment first given, and the diet restricted. A little later he was given a tonic, as follows: \mathcal{R} Ferri et ammon. citrat., \mathfrak{z} i; tincturæ nucis vom., \mathfrak{z} ij; tincturæ cinchon. comp., \mathfrak{z} iv. \mathfrak{m} . Teaspoonful, after eating, in water; and was also given Horsford's acid phosphate, a teaspoonful before meals.

One month later, December 8th, it was recorded that the face was very much better, there being almost no lumps or pustules; some redness still remained, although all of its fiery character was gone.

Acne may not infrequently occur in connection with other eruptions, and care is often necessary in differentiating its lesions from others, as it is often the case that a single individual will have two or more entirely distinct eruptions at the same time, or in rapid succession.

Mr. Wm. — aged thirty-two, came under my care Oct. 12, 1874, for the treatment of a large tubercular and ulcerating syphilitic eruption occupying most of the right auricle. For this he was put upon a mixed treatment, under which it was about healed within a month. He was then seen occasionally, he taking the medicine meanwhile.

In October of the following year, he again called, not having taken any medicine since August. The former eruption had entirely disappeared, and he now came for advice concerning a very severe acne, affecting principally the back, but present also upon the chest, neck, and face. The back presented a remarkable aspect; from the shoulders almost to the hips there were innumerable scars of preceding lesions, some round, most of them oval, some pigmented, many perfectly pale. Scattered among them were numerous large pustules and indurated masses containing pus, and many large comedones. The same existed on the front of the chest to a lesser degree, also on the neck, and a few upon the face. The lumps were mainly painless on pressure, of an indolent character, and of a purplish red; most of them somewhat oval.

He was given acetate of potassa to be taken three times daily after eating, and was directed to continue the pills of proto-iodide of mercury in half-grain doses, morning and night, as he had been taking them for his syphilis. Locally he was to wash the chest and back every morning with soap and cold water, using much friction. Three months later it was recorded that his acne had about disappeared, leaving only the formerly existing scars. Seven months later he returned for treatment of the acne; he had become careless in diet, eating much of fried articles, and taking

much tea, and the eruption had slowly increased again, and many fresh lesions were then present. He was once more put under active measures, and was not seen again for three years, when he returned because of debility. It was learned that he had continued the treatment for a considerable time, and had remained free from the acne, except that he had occasional spots when constipated. No further signs of his syphilis have ever appeared.

Remarks.—Acne indurata, more than almost any other of the forms of acne, is very intimately connected with the state and condition of other organs, or of the system at large; local treatment is most futile as regards permanent effects, unless combined with radical and efficient management of the general health, and of organs or functions particularly disordered. It is not always possible to fix exactly upon the diseased organ which is to blame, and which requires treatment; often it appears to be simply a general debility, and a consequent weakness of skin tissue, in which the habit of disease once begun is perpetuated. This seemed to be the case in the first patient mentioned, where the eruption had lasted almost continuously for about fourteen years, and no disease of other organs could be discovered, but the general tone was far below par, and tonics really cured the case. The same was true of the third case.

The second and fourth cases demonstrate strongly the connection of the eruption with internal disorders, as could be shown by scores of other cases. With each recurrence of dyspeptic or sexual disturbances the eruption broke out with fresh vigor; in the second instance the well-marked and recognized uterine disease undoubtedly prevented a complete recovery. While local measures often will suffice in young people with acne simplex, or those in older years with acne rosacea, in acne indurata the deep-seated infarctions take place in spite of the most careful and complete local treatment, and only the closest medical observation and most assiduous and intelligent medical skill will suffice to permanently remove the eruption.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

One Hundred and Twenty-ninth Regular Meeting, September 26, 1882.

REPORTED BY DR. W. T. ALEXANDER, SECRETARY.

Dr. A. R. ROBINSON presented the following case of

Sclerema neonatorum.

The patient was a male child, seven months old. The mother had had syphilis a number of years ago, and last year Dr. Robinson removed a spindle-celled sarcoma from the scapular region. The child had a great many convulsions during the first twenty-four hours of its life, and on the third or fourth day jaundice of an intense degree set in, and lasted several weeks. It had always passed but a small quantity of urine, of a deep color. The disease of the skin was first noticed on the second day, in the form of an induration over the buttocks, extending from the upper borders of the ossa innominata down the outer aspect of the thighs as low as their middle thirds, the rest of the body remaining free. The child is well nourished, and is now steadily improving. The skin is not unusually pale at the seat of disease, is moderately œdematous, and can be moved over the surface of the indurated mass, which is sharply defined and of a dense consistence. The skin has at no time felt cooler to the touch than the rest of the body. The disease is slowly spreading downward, affecting first the subcutaneous tissues, and later the corium, as shown by the fact that the latter can be raised in folds over the lower end of the induration, whereas it is only slightly movable over the upper portion of the mass.

Dr. WEISSE remarked that this case of sclerema reminded him of one that he had had under treatment some years ago. The disease was more extensive than in this instance, having begun at the back of the neck and extending over all the body and the back

of the legs. Baths of very hot water, with alkalies added, did great good in that case. The boy is now twelve or thirteen years old, and although enjoying comparatively good health, he is not sturdy. He also remembered a second case in which the result was the same.

Dr. PIFFARD could recall only one case under his personal observation. In the present instance the infiltration seems to be in the subcutaneous tissues, and not in the skin. In scleroderma of adults the cutis cannot be moved, the infiltration being in the skin itself. The prognosis in sclerema neonatorum is far better than in the latter disease, except in the acute form of scleroderma of adults, which generally recovers.

Dr. TAYLOR had seen two cases, in both of which the disease extended over the entire body, and in both recovery was perfect. The children were two or three weeks old when he saw them. Both the skin and subcutaneous tissues were involved, the disease presenting a thickening of the entire skin, which was immovable, and showed slight redness after pressure. No treatment was employed except inunctions.

Dr. ROBINSON said that the situation of the disease in this case was unusual. He said that the best article that we have on the subject is that in the second volume of "*Gerhardt's Handbuch der Kinderkrankheiten*." When the disease attacks the chest there are usually interference with respiration, and a slow pulse. As a rule, the bodily temperature in this disease is subnormal, but the only time it was taken in this case it was found to be 101° in the rectum, and that at a time when there was no colitis or dysentery to account for the rise. This child has had acid dyspepsia, and also diarrhoea. The disease attacks the fatty portions of the skin at first, and subsequently invades the corium. In the article alluded to it is stated that the disease ordinarily terminates fatally in about a month, but in this case he entertains a favorable prognosis, as the child is steadily improving.

Dr. BULKLEY thought it curious that, although the disease is generally held to be a fatal one, a number of cases have been described to-night all of which recovered.

The next patient shown was sent by Dr. Fox, and was a case of

General diffuse psoriasis,

in which the right half of the body had recently been painted over with a chrysophanic acid varnish.

The following letter was sent by Dr. Fox :

"The beneficial effect of the application is evident, and the case shows that the acid does not necessarily stain the clothing. In this case, and I have noticed the same thing in other cases, the untreated side has undergone considerable improvement. This may not prove the constitutional action of the drug, but the fact remains to be explained. The varnish referred to is a partial

solution and suspension of chrysophanic acid (ten per cent.) in flexible collodion. The powder is first rubbed with a little alcohol and ether, then added to the collodion and well shaken. The varnish produces less effect than a chrysophanic acid ointment of equal strength, but when applied to patches from which the scales have been removed, it is very efficient, and when it has been allowed to dry for about ten minutes it does not stain the clothing of the patient."

Dr. PIFFARD expressed his conviction that Dr. Fox had made a decided advance in our methods of applying chrysophanic acid, by means of the varnish that he had used in this case.

Dr. BRONSON questioned whether in this method danger might not sometimes arise from suppressing the action of the skin.

The next case was presented by Dr. WEISSE, and exhibited an unusual form of

Ichthyosis.

The patient was a boy, ten years old, who was born with a scaliness of the skin. Dr. Weisse saw him first when eighteen months old, again three years ago, and for the third time the day before this meeting. At first the child was very puny and feebly developed, presenting a dry and parched condition of the skin, with a great deal of cracking of the epidermis, causing bleeding at the flexures of the articulations. Warm baths, alkalies internally, and inunctions of sweet oil were ordered, and used with benefit. Three years ago the patient began to have trouble with his eyes, which led to double ectropion, and the development of opacities on the cornea interfering with sight.

The entire surface is the seat of an ichthyotic condition, the skin being hard, stiff, and moderately scaly; the flexures are also involved. The nails were improperly developed, but are improving at present. The fingers also show retarded development as compared with the rest of the hands, are drawn toward the ulnar side, and are somewhat clawed. The hair of the head is thin and sparse, and the eyebrows scattered. The teeth were slow in appearing, but the second set are coming in better. Nutrition is, on the whole, well performed, and the boy is of average size. The skin had been kept in fair condition by treatment. The ears are closely fastened down to the head, and the edges of the auricles are broad and thick.

The child's mother says that there is now less scaliness than there was formerly, and that she has noticed no difference in the child's condition between winter and summer. The child gets very red when warm, but never perspires. He suffers a great deal from the cold. The mother has three other children, two younger than this one, all in perfect health. This boy is the brightest of the family, and is decidedly self-willed. The family history is free from constitutional taint.

Dr. PIFFARD, in speaking of the diagnosis of the disease, said that psoriasis could be eliminated from consideration, on account of the facts, that the disease is universal in this case, that the skin shows but a thin layer of scales, and that it is not worse about the elbows and knees, and also by the fact that here the trouble is a congenital one. It has, in parts, an eczematous aspect, especially about the flexor surfaces, but this may be present in mild cases of ichthyosis. The history of this case alone is sufficient to warrant us in making a diagnosis of ichthyosis, rather than psoriasis, eczema, pityriasis rubra, or dermatitis exfoliativa.

Dr. MORROW had never seen an ichthyosis so universal as this, in which the axillæ, flexures, and the scalp were all involved. The fact that it is congenital, however, points to ichthyosis, although the circumstance that it is not more developed on the outer aspects of the extremities is peculiar. Ichthyosis, also, always improves in summer, in his experience, which is not the case here.

Dr. ROBINSON said that the red, almost eczematous appearance of the body, was remarkable. As regards treatment, he alluded to one case in which the disease almost entirely disappeared under the use of linseed oil, although it afterward relapsed.

Dr. BULKLEY could see no reason why eczema could not co-exist with ichthyosis, and regarded the case as one of ichthyosis with a subsequent development of eczema. He has frequently seen the two diseases in conjunction. For treatment of this case he would suggest baths, and linseed oil in- and externally.

Dr. TAYLOR did not look upon the case as one of ichthyosis, in which disease the scales are more branny than here, and the flexor surfaces are not more involved than the rest of the body, as is here the case. The effects upon the auricles in this case are also unlike any thing in ichthyosis. Here they are held firmly down to the scalp by exuded inflammatory material. In ichthyosis the fingers do not become clawed and distorted, as is the case in this patient. He was inclined to regard it as a case of pityriasis rubra.

Dr. PIFFARD, in speaking on the subject of treatment, showed two photographs, illustrating the very beneficial results of the use of pilocarpin. He also stated that Lombroso had reported a case of cure of ichthyosis by *Ustilago Maidis*.

Dr. SHERWELL said that he had seen the case for a moment only, and was then inclined to regard it as one of pityriasis rubra. But from the answers to the questions put by Dr. Piffard, and the fact that it was congenital, he now believed it a case of ichthyosis.

The Society then discussed the following conclusions which had been formulated by Dr. MORROW at the request of the Society, after remarks by him on the subject at the preceding meeting, the discussion of which was made the special order for the evening.

The therapeutical value of chrysophanic and pyrogallic acids.

"1. That chrysophanic acid is perhaps the most efficient agent known to the profession for the external treatment of certain cases of psoriasis, especially chronic cases which have resisted other methods of treatment.

"2. That its range of application is limited ; in children, in patients with sensitive, irritable skins, and in acute cases, generally, it is contra-indicated.

"3. That in psoriasis affecting the face and hairy scalp, the intensely irritating action producing puffiness of the face and eyelids, and its discolored effect upon the hair render its employment impossible.

"4. That it is prompt in its action, a week or ten days' active treatment being usually sufficient to develop its full therapeutic efficacy.

"5. That its curative effect is only temporary ; it does not afford a safeguard against relapses.

"6. That it probably acts only locally and by virtue of its irritating properties, setting up a substitute inflammation, which modifies or corrects the tendency to the inflammatory overgrowth of epidermic cells.

"7. That its employment is attended with certain objectionable results, some of which always follow its use, while others seem to depend upon idiosyncrasy, physiological and morbid predispositions, etc.

"8. That a brownish, prune-juice discoloration of the skin which persists long after the application is discontinued, a reddish staining of the hair and nails, and an indelible dyeing of the clothing are inseparable from its use.

"9. That the erythematous and furuncular inflammations which occasionally follow its use may be classed as incidental effects, as they do not always depend upon an excessive strength of the preparation employed, but are frequently manifest after a mild application ; intense dermatitis, resulting in exfoliation of the epidermis in large flakes, has been observed after an application of ten grs. to the ounce.

"10. That the strength of the ointment recommended by Balmanno Squire (3 ii to $\frac{3}{4}$ i) is excessive ; a milder strength (20 grs. - $\frac{3}{4}$ i to $\frac{3}{4}$ i) being usually sufficient to develop the full therapeutic virtues of the drug.

"11. That in other diseases for which it has been recommended, as acne, favus, pityriasis versicolor, eczema marginatum, etc., chrysophanic acid possesses no advantages over certain other drugs which are commonly used.

"12. That pyrogallic acid is a drug which is free from some of the more objectionable features of chrysophanic acid. It does not (in ten per cent. ointment) inflame the skin, it does not produce œdema of the face when applied to the scalp, and the discoloration is much less marked and permanent.

"13. That it should, nevertheless, be used with caution, as pernicious results have followed its too free use. When freely used for two or three weeks it produces an olive green or tarry condition of the urine, with prostration, febrile disturbance, and other general symptoms.

"14. That its curative action in psoriasis is much less rapid, but apparently more permanent than that of chrysophanic acid.

"15. That its freedom from irritation and its absence of odor render it an admirable substitute for chrysophanic acid and oil of cade in diseases affecting the scalp and face.

"16. That while its effect in psoriasis is slower and less brilliant than that of chrysophanic acid, its range of therapeutical action is much more extended. It causes to disappear the nodosities of lupus, the hyperplasiæ of syphilis, epidermic and papillary hypertrophies, and seems to have a good effect in promoting the cicatrization of wounds.

"17. That it seems to act by virtue of its stimulant and irritating properties; it hardens and shrinks the tissues, shrivels up unhealthy granulations, and acts as a hemostatic."

Dr. WEISSE had used chrysophanic acid a good deal in psoriasis, and had found it to answer his expectations admirably. As regards its mode of action, he had come to regard it as purely a local one. He usually ordered the scales removed from the patches as far as possible, before applying the acid, by means of hot alkaline baths, recommending that the acid be applied twenty-four hours or so later. He thought that he obtained better results by this preliminary measure. In his early experiences with psoriasis he had good results from the local use of creasote, but its disagreeable odor caused him to cease employing it. He regarded local applications as the most efficient means of treating psoriasis. He agreed with Dr. Morrow's conclusion, that recurrences ordinarily take place after the disease is removed by chrysophanic acid, as after other methods of treatment.

Dr. SHERWELL thought that Dr. Morrow's conclusions were so just that they would be agreed with by the majority of dermatologists. He believed that ointments of chrysophanic acid of the strength used by Squire and those who followed his advice ($\frac{3}{4}$ ss- $\frac{3}{4}$ i to $\frac{3}{4}$ i) were entirely too strong. He himself never used it in a greater strength than ten grains to the ounce, and often prescribed seven or even five grains to the ounce. He stated that chrysophanic acid is, as is well known, but sparingly soluble in water; whether its active principle was so soluble or not, was a question. In hospital practice he had recently ordered the application of an ointment of five grains of the drug to the ounce. The interne was unfamiliar with the use of the agent, and attempted to grind the acid up in water, triturating it freely, and then applied the supernatant liquid (which doubtless also contained some of the acid in suspension) to the skin of the patient. The application excited an erythema, but also caused a disappearance of the original disease in a remarkable manner, much more speedily than the

drug usually does when applied in ointment. He (Dr. S.) was so much struck by the result that he had determined to make further trial of the method. He agreed, in the main, with Dr. Morrow's conclusions.

Dr. TAYLOR stated that Dr. Morrow's conclusions were, on the whole, identical with those that he himself had embodied in a paper read before the American Medical Association, in 1880. He had then raised his voice against the abuse of a valuable remedy, in the excessive concentration that was then recommended by Squire. Of pyrogallic acid he would only say that his experience with it had been much less happy than with chrysophanic acid.

Dr. BULKLEY desired to lay stress upon the conclusion of Dr. Morrow, that chrysophanic acid did not prevent relapses in psoriasis. It is important for the Society to endorse this, if it should see fit to do so. He himself had, as a rule, seen relapses after cures by it. As regards the statement that it probably acts by virtue of its local irritant effects, he would call attention to the cures which had been reported to follow the internal use of the drug, either in pills or in powder, in large doses, sometimes as high as five grains. He had made a number of experiments of this kind, but was not yet prepared to state the results. It does, however, seem in some cases to exert a decided beneficial effect when taken internally. As regards the strength of ointment to be used, he had not found that small quantities of the drug were always sufficient, having had one patient who used it the strength of 3 iii to 3 i before the eruption would yield. He thought this justifiable in some cases, but would, nevertheless, usually begin with a strength of twenty grains to the ounce.

As regards pyrogallic acid in epithelioma, he had ordered the pure acid sprinkled on, and poultices afterward applied over the lesion, and had found that its effect in cutting down the epitheliomatous granulations was often wonderful. He recalled particularly one case of a large epithelioma of the temple, in which a pyrogallic acid ointment was used without subsequent poulticing, and when he last saw the patient, the ulcer was almost entirely healed.

Dr. ROBINSON agreed with almost all of Dr. Morrow's conclusions, but desired to criticize his statement that "chrysophanic acid probably acts only locally and by virtue of its irritating properties." He did not believe that its action is due to its directly irritating effects *alone*, since he had not obtained his best results in those cases in which the drug excited much irritation. He had seen cases recover under its use without the production of any recognizable signs of irritation, such as hyperæmia, swelling, transudation, etc.

Dr. DENSLOW remarked that he had recently made trial of another drug in the treatment of psoriasis, in cases of tender skins, on the face and scalp, and in children, where he regarded chrysophanic acid as contra-indicated. This agent was the oil of turpentine, used at first in the strength of one part to four, or one to

three, gradually increased to equal parts of the oil and olive oil. He had applied it by friction with a cork covered with flannel, as recommended by Dr. Piffard. In many cases he has found this agent to act as well as chrysophanic acid ever does, and it neither produces staining nor irritating effects.

Dr. PIFFARD said that he agreed fully with sections, 1, 2, 3, 5, 7, 9, 10, and 13 of the report. As regards section 4, his experience had been different from that of the author of the paper. He had found it desirable to keep up the action of the drug for a longer period, sometimes for at least one month. He usually began treatment with an ointment of ten grains to the ounce, and gradually increased to one drachm to the ounce, and, as a rule, with great benefit to his patients. With regard to section 6 of the report, that the drug acts by virtue of its irritating properties, he was of a different opinion. It probably does not act by these alone, but doubtless has also some constitutional action. As to the discoloration produced, it did not seem to him that it lasts so long as intimated in the paper; it generally disappearing in from two to three weeks, in his experience. The color produced was, he thought, often a beautiful Indian red, rather than brownish, or of that of the juice of prunes. As regards the use of the drug in pityriasis versicolor, the "chromophytosis" of our nomenclature, he thought it wonderfully efficient, and in so-called eczema marginatum he thought it one of our most valuable agents. He had never had any success with it in ringworm of the scalp, but had often found it very useful in ringworm of the body.

The discoloration produced by pyrogallallic acid he had found to be black or brownish. He did not use this agent as much as he did chrysophanic acid, having had one or two unpleasant experiences with it. With regard to section 13, he thought that it was not put with sufficient force. Pyrogallallic acid is a dangerous drug when extensive applications of it are made. It has been found to kill dogs experimented upon with it. It is well known that it is absorbed by the skin, and that it is one of the most active reducers known to chemists. It is capable of deoxidizing almost all bodies that will give up their oxygen, and probably exerts this action upon the blood corpuscles when absorbed. With regard to section 14, he had no valuable experience to communicate, having abandoned the use of the drug (pyrogallallic acid) in psoriasis and kindred diseases. In conditions characterized by epidermic proliferation, he much preferred chrysophanic acid. He was aware that pyrogallallic acid had been highly recommended in epithelioma and venereal ulcers.

With regard to the staining of the clothing caused by chrysophanic acid, it seemed to him that the method introduced by Dr. G. H. Fox, using the pure powder, and afterward painting it over with collodion, would obviate that drawback to the use of the agent. Scarenzio used collodion in 1879 to limit the extension of the inflammation produced by the drug to the diseased patch, his method being to surround the patch to be treated with a ring of this fluid before applying the acid.

In conclusion he stated that he had met cases of psoriasis in which chrysophanic acid did not seem to exert the slightest effect, and he had seen other instances in which it did positive harm, causing the eruption of fresh patches of the disease in the erythematous areolæ which it excited around old patches. He had also sometimes noticed that it failed to remove the disease when it had relapsed, although it had caused its disappearance when used the first time.

Dr. BRONSON called attention to the fact, that no allusion had been made to the name of the first of the two drugs under discussion. He thought it strange that the name "chrysophanic acid" was still used, although Liebermann had shown that it should be called "chrysarobin." He (Dr. Bronson) thought that the points of Dr. Morrow's paper were so well taken that they were almost axiomatic. He desired, however, to express his dissent from the view advanced, that the action of chrysophanic acid was only a local one, in view of the reported instances in which the drug was applied only to limited portions of the body, and had nevertheless cured the disease in other parts. He believed that even when the scales are not previously thoroughly removed from the diseased patches, the effect of the drug is often wonderful, and he had sometimes thought that its effect upon the sound skin between the patches was of great value in hastening a cure. He described a case in illustration of the unpleasant effects of the drug, that of a surgeon who, to relieve an eczema marginatum between the thighs from which he suffered, applied a strong ointment of Goa powder. It seemed at first to limit the disease, but later produced an explosion of an eczematous nature, of an exceedingly violent character, evidently the effect of a toxic action of the Goa powder. It proved one of the most obstinate cases that he had ever encountered.

Dr. MORROW stated that he always directed the scales of psoriasis to be removed before applying the acid, either mechanically, or by the use of salicylic acid,—one part in sixteen of alcohol. This also removed the greasiness of the skin, and seemed to help the subsequent action of the chrysophanic acid. As regards the beneficial action of the drug upon parts other than those to which it had been applied, he had found reports of only one or two cases where this was said to be the case. In one of these cases (reported by Charteris) the drug was applied to one half of the body only, the other being wrapped in flannel. When this was removed two or three weeks later, marked improvement was found to have taken place in the diseased patches, with which the acid had never come in contact. He believed that the results of the internal use of the drug were quite negative. He desired to emphasize the statement that certain skins will not tolerate chrysophanic acid. In one case he had found that five or even three grains of the acid to the ounce developed intense dermatitis. In another case, a young girl, even two and a half grains to the ounce were not tolerated, the whole epidermis desquamating in large flakes when an ointment of this strength was applied.

He had used pyrogalllic acid in lupus, and with very good results. As to the discoloration of the skin produced by this agent, it had been observed that the brownish or blackish hue was usually most marked on the palms and soles. This circumstance was by some ascribed to the great abundance of sweat-glands in these localities. He confessed himself unable to judge of the value of this explanation, but would like to see the drug tried upon the patient exhibited (by Dr. Weisse) this evening, who presented the peculiarity of never sweating, and therefore presumably had no sweat-glands.

Dr. SHERWELL suggested that the deeper discoloration of the palms and soles might be due to the greater thickness of the epidermis in those parts.

Dr. TAYLOR declared himself as loth to theorize, as a rule, and he therefore desired to protest against the long-exploded humoral theory of the mode of action of chrysophanic acid which had been alluded to this evening. If he should form a theory, it would seem much more plausible to him to regard the action of the drug as a reflected one, through the nerves to the spinal cord, and back again upon the skin. This hypothesis would explain the action of the agent in those cases in which it produces effects upon parts to which it was not applied.

Dr. PIFFARD remarked that both the theory advanced by Dr. Taylor and that which attributed the effects of the drug to absorption into the blood could be supported by analogy, and that a very striking analogy to the latter theory was furnished by the effects of mercurial inunctions, which, it was universally admitted, removed lesions in distant parts of the body by acting upon them through the blood.

CLASS	I.	Morbi cutis parasitici.	Parasitic Affections.
"	II.	Morbi glandularum cutis.	Glandular Affections.
"	III.	Neuroses.	Neurotic Affections.
"	IV.	Exsudationes.	Exudative or Inflammatory Affections.
"	V.	Hæmorrhagiæ.	Hæmorrhagic Affections.
"	VI.	Hypertrophix.	Hypertrophic Affections.
"	VII.	Atrophix.	Atrophic Affections.
"	VIII.	Neoplasmata.	New Formations.

A. VEGETABLE.

1. *Tinea trichophytina* (or trichophytosis) { *corporis* (or *tinea circinata*).
capitis (or *tinea tonsurans*).
parasite—Trichophyton tonsurans. { *barbæ* (or *sycosis parasitica*).
cruris (or *eczema marginatum*).
2. *Tinea favosa* (or favus) (*parasite—Achorion Schænleinii*).
3. *Tinea versicolor* (or chromophytosis) (*parasite—Microsporon furfur*).

B. ANIMAL.

1. Phthiriasis (or pediculosis) { *corporis*
capitis } (*parasite—Pediculus*).
pubis
2. Scabies (*parasite—Acarus scabiei*).

A. DISEASES OF THE SEBACEOUS GLANDS.	I. Due to faulty secretion or excretion of sebaceous matter.	1. Acne sebacea	{ oleosa cerea cornea }	(or seborrhœa).
		2. Acne punctata	{ nigra (or comedo). albida (or milium).	
		3. Acne molluscum (or molluscum sebaceum).		
	II. Due to inflammation of sebaceous glands with surrounding tissue.	{ 4. Acne simplex (or vulgaris). 5. Acne indurata. 6. Acne rosacea.		
B. DISEASES OF THE SWEAT- GLANDS.	I. As to quantity of secretion.	{ 1. Hyperidrosis. 2. Anidrosis.		
		II. As to quality of secretion.	{ 3. Bromidrosis. 4. Chromidrosis.	
	III. With retention of secretion.	{ 5. Dysidrosis. 6. Sudamina.		

Class III. Neuroses. Neurotic Affections.

1. Zoster (herpes zoster or zona).
2. Pruritus.
3. Dermatalgia.
4. Hyperæsthesia cutis.
5. Anæsthesia cutis.
6. Dystrophia cutis (or trophic disturbances).

Class IV. Exsudationes. Exudative or Inflammatory Affections.**A. INDUCED BY INFECTION OR CONTAGION.****I. Erythematous.**

1. Rubella (or measles).
2. Rötheln (or German measles).
3. Scarlatina.
4. Variola.
5. Varicella.
6. Vaccinia.
7. Syphilis.
8. Pustula maligna.
9. Equinia (or glanders).
10. Diphtheritis cutis.
11. Erysipelas.

II. Papular.

1. Roseola.
2. Erythema { simplex.
multiforme.
3. Urticaria. { nodosum.
4. Lichen { simplex.
planus.
ruber.
scrofulosus.
5. Prurigo.

III. Vesicular.

6. Herpes { febrilis.
iris.
progenitalis.
gestationis.
7. Hydroa.

IV. Bullous.

8. Pemphigus { vulgaris.
foliaceus.
9. Pompholix (or cheiro-pompholix).

B. OF INTERNAL OR LOCAL ORIGIN.**V. Pustular.**

10. Sycosis (or folliculitis pilorum).
11. Impetigo.
12. Impetigo contagiosa.
13. Ecthyma.

VI. Multiform, i. e., erythematous, papular, vesicular, pustular, etc.

14. Eczema.
15. Dermatitis { calorica.
venenata.
traumatica.
medicamentosa.

VII. Squamous.

16. Dermatitis exfoliativa (or pityriasis rubra).
17. Psoriasis.
18. Pityriasis capitis.

VIII. Phlegmonous.

19. Furunculus (furunculosis).
20. Anthrax.

IX. Ulcerative.

21. Onychia.
22. Ulcus { simplex.
venereum.

Class V. Hæmorrhagiæ. Hæmorrhagic Affections.

1. Purpura $\left\{ \begin{array}{l} \text{simplex.} \\ \text{papulosa.} \\ \text{rheumatica (or peliosis rheumatica).} \\ \text{hæmorrhagica.} \end{array} \right.$
2. Hæmatidrosis (or bloody sweat).
3. Scorbutus.

Class VI. Hypertrophix. Hypertrophic Affections.

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| A. OF PIGMENT. | $\left\{ \begin{array}{l} 1. \text{Lentigo.} \\ 2. \text{Chloasma.} \\ 3. \text{Melanoderma.} \end{array} \right.$ | $\left\{ \begin{array}{l} 4. \text{Nævus pigmentosus.} \\ 5. \text{Morbus Addisonii.} \end{array} \right.$ |
| B. OF EPIDERMIS AND PAPILLÆ. | $\left\{ \begin{array}{l} 1. \text{Keratosis pilaris (or lichen pilaris).} \\ 2. \text{Ichthyosis.} \\ 3. \text{Cornu cutaneum.} \\ 4. \text{Clavus.} \\ 5. \text{Tylosis (or callositas).} \end{array} \right.$ | 6. Verruca $\left\{ \begin{array}{l} \text{vulgaris.} \\ \text{senilis.} \\ \text{acuminata.} \\ \text{necrogenica} \end{array} \right.$ |
| C. OF CONNECTIVE TISSUE. | $\left\{ \begin{array}{l} 1. \text{Scleroderma.} \\ 2. \text{Sclerema neonatorum.} \\ 3. \text{Morphœa.} \end{array} \right.$ | $\left\{ \begin{array}{l} 4. \text{Elephantiasis (Arabum).} \\ 5. \text{Dermatolysis.} \\ 6. \text{Frambœsia (or yaws).} \end{array} \right.$ |
| D. OF HAIR. | 1. Hirsuties. | 2. Nævus pilosus. |
| E. OF NAIL. | 1. Onychogryphosis. | 2. Onychauxis. |

Class VII. Atrophix. Atrophic Affections.

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| A. OF PIGMENT. | $\left\{ \begin{array}{l} 1. \text{Albinismus.} \\ 2. \text{Leucoderma (or vitiligo).} \\ 3. \text{Canities.} \end{array} \right.$ |
| B. OF CORIUM. | $\left\{ \begin{array}{l} 1. \text{Atrophia cutis} \left\{ \begin{array}{l} \text{propria.} \\ \text{linearis (or striæ atrophicæ).} \\ \text{maculosa (or maculæ atrophicæ).} \end{array} \right. \\ 2. \text{Atrophia senilis.} \end{array} \right.$ |
| C. OF HAIR. | $\left\{ \begin{array}{l} 1. \text{Alopecia.} \\ 2. \text{Alopecia areata.} \\ 3. \text{Trichorexis nodosa (atrophia pilorum propria, or fragilitas crinium).} \end{array} \right.$ |
| D. OF NAIL. | Onychatrophia. |

Class VIII. Neoplasmata. New Formations.

I. BENIGN NEW FORMATIONS.

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| A. OF CONNECTIVE TISSUE. | $\left\{ \begin{array}{l} 1. \text{Keloid.} \\ 3. \text{Xanthoma (xanthelasma or vitiligoidea).} \end{array} \right.$ | $\left\{ \begin{array}{l} 2. \text{Fibroma (or molluscum fibrosum).} \\ \end{array} \right.$ |
| B. OF GRANULAT-ION TISSUE. | $\left\{ \begin{array}{l} 1. \text{Lupus} \left\{ \begin{array}{l} \text{vulgaris.} \\ \text{erythematosus.} \end{array} \right. \end{array} \right.$ | $\left\{ \begin{array}{l} 2. \text{Scrofuloderma.} \\ 3. \text{Rhinoscleroma.} \end{array} \right.$ |
| C. OF BLOOD-VESSELS. | $\left\{ \begin{array}{l} 1. \text{Nævus vasculosus.} \\ 2. \text{Angioma (or telangiectasis).} \end{array} \right.$ | |
| D. OF LYMPHATICS. | $\left\{ \begin{array}{l} 1. \text{Lymphadenoma cutis.} \\ 2. \text{Lymphangioma cutis.} \end{array} \right.$ | |
| E. OF NERVES. | Neuroma cutis. | |

II. MALIGNANT NEW FORMATIONS.

1. Lepra $\left\{ \begin{array}{l} \text{tuberosa} \\ \text{maculosa} \end{array} \right\}$ (leprosy, or elephantiasis Græcorum).
2. Carcinoma.
3. Epithelioma.
4. Sarcoma $\left\{ \begin{array}{l} \text{idiopathicum.} \\ \text{pigmentosum (or melanosis).} \end{array} \right.$

I.

DISEASES OF THE SKIN.

EXUDATIVE OR INFLAMMATORY AFFECTIONS INDUCED BY INFECTION OR CONTAGION.

ROBERT CAMPBELL, M.D.

The presence of the micrococcus in the blood of malignant measles; its importance in treatment.—Dr. JOHN M. KEATING, in an able paper on this subject, arrives at the following conclusions:

“The micrococcus is found in the contents of pustules and vesicles, and also in the blood taken from the measles papule, in ordinarily mild cases, without its being present in the blood taken from the punctured finger. In severe cases, called malignant in this paper, owing to the rapid appearance of morbid symptoms, the blood shows early in the attack numerous patches of micrococcus in the field.

“In cases of rapid sthenic disease, with high temperature and great tissue-change, the evidences of large quantities of fibrin with a tendency to coagulation are manifest. The rapid production of micrococci soon gives the mechanical impediment, and if stasis takes place from any other obstruction to the circulation, clots rapidly form.

“The non-appearance of clots in malignant fevers attended with fluid blood, such as low forms of typhus, diphtheria, etc., is simply due to the fact that rapid tissue-changes have resulted in decomposition, instead of into fibrin-forming substances,—no fibrin is formed, hence no clots,—but the micrococci are present all the same. These cases are held by some to be malignant ones, but I think the *foudroyante* character of the others just mentioned, entitles them to be placed in the same category.

“But the micrococcus, if left unheeded, may attack the white corpuscle, as distinctly seen under the microscope, and destroy its contents. The red cells also change in appearance, and finally probably become, to all intents and purposes, useless in the economy. When such a condition is seen by the microscope and found extensive, a fatal prognosis can be given, despite the most active treatment.

“In cases where the white blood-cells are as yet unaffected, treatment, when active, will be followed by good results, provided the other complications, as visceral inflammation, etc., are not in themselves excessive.

“Alcohol seems in some way, when given in large amounts, to check the progress of the marauders, to arrest the process of destruction, and, if needful, can be associated with quinine and iron

in small, repeated doses, digitalis perhaps, and frictions, baths, and poultices, etc. As we have seen, the symptoms presented are contemporary with the changes going on within the blood; they may, in lieu of a careful microscopic examination of the blood, be taken as a gauge for treatment; knowing what can and will take place, early active treatment will give the patient some chance for the future."—*Phila. Med. Times*, August 12, 1882, p. 763.

Swelling of lymphatic glands in r  theln.—Dr. BLOCH, of Copenhagen, has, during a recent epidemic of r  theln, treated eighteen patients affected with that disease. Four of these he treated in 1880 for indubitable measles.

His first patient was a five-year-old boy. He had a slight fever, and the only sign of disease was a group of swollen glands on both sides of the neck, corresponding with the upper third of the posterior edge of the sterno-cleido-mastoideus muscle. It formed a very prominent tumor, larger than an English walnut, composed of swollen, smooth, roundish, slightly tender glands. The mucous membrane of the throat was normal, and there was no pain there. The next day his sufferings were more marked. There were symptoms of laryngeal catarrh, but the lungs were entirely free from mucus. He had a slight conjunctivitis of the eyelids, and on the face a beginning efflorescence of r  theln, which the next day spread all over the body. The following day the efflorescence had partly disappeared, and his feeling of malaise had ceased. The swelling of the glands disappeared after eight days.

B. examined seventeen other patients suffering from r  theln, and found swollen cervical glands in all of them. Most frequently those situated at the posterior border of the sterno-cleido-mastoideus muscle were alone affected, especially those behind the upper or two upper thirds of the muscle. In two cases the swelling extended along the whole posterior border. In three patients there was at the same time enlargement of the occipital glands, and in one of these also swelling of a gland on one processus mastoideus. Finally, in one patient the gland behind the sterno-cleido-mastoideus muscle, the submaxillary and sublingual glands were swollen on both sides. The time of the appearance of this swelling was noted in four cases. In all these it appeared before the efflorescence. With the exception of the first case the swelling was not great enough to cause any deformity. It varied in size from that of a pea to that of an almond. The soreness on pressure was troublesome only in four cases (those in which the occipital glands were swollen, and the one with swelling of the submaxillary and sublingual glands). With the exception of the first patient all complained of pain in the throat, but in one only, who habitually suffered from slight attacks of angina, was there a slight redness of the mucous membrane covering the tonsils. There was a sensation of stiffness with certain movements of the neck and the head, and the pain was therefore attributed to the

sore glands. In all of the cases the tenderness disappeared simultaneously with the exanthem, and the swelling more gradually.

B. is inclined to believe that this swelling of the cervical glands might be characteristic of rubeola, and that its presence may aid us in the difficult diagnosis between rubeola, *i. e.*, r  theln, and morbilli, *i. e.*, measles.

Most authors do not mention this symptom, but it has not escaped the attention of all. Thus Thomas ("Handbuch der speciellen Pathologie und Therapie von Ziemssen," Leipzig, 1874, vol. ii) says: "Rubeola is a specific, contagious, most frequently epidemic disease," and also: "In connection with the affection of the mucous membrane lining the mouth and the throat we find not constantly, but according to the observation of several authors (Thierfelder, Mettenheimer), the lymphatic glands of the neck swollen. Generally this swelling is moderate, although sometimes it is so great as to cause a local   dema. In other parts of the body sometimes swollen glands are also found, but, according to my experience, by no means as a rule. According to Thierfelder, the swelling of the auricular and jugular lymphatic glands was the only constant prodromal symptom, and could often be observed as late as the third week after the beginning of the disease."

In a discussion in the Medical Society of Christiania Nov. 17, 1880, Dr. Sch  nberg, who believes r  theln to be a disease *sui generis*, mentioned what seemed to be a characteristic symptom of r  theln, *viz.*, a sensation of stiffness in the posterior part of the neck, which makes its appearance before the eruption, and which is rather constant in its appearance. In that locality are found small glandular swellings, varying in size from that of a pea to that of a bean. English authors have noticed these swollen glands.

B. does not believe that these glandular swellings are referable to the affection of the throat. They are found in the prodromal stage of r  theln, but not in measles although in this latter disease the throat is greatly affected.—Abstracted by Dr. H. J. Garrigues, from *Hosp. tidende*, vol. ix, No. 6, Feb. 8, 1882.

Two cases of typhus, coexistent, during the latter part of their progress, with scarlet fever.—Dr. JOHN S. MAIN reports the following cases: A father and two sons were admitted to hospital, suffering from typhus fever of a very severe type. The father died. In both boys' cases, who recovered, there were, during convalescence, distinct evidences of commencing desquamation, and on examining their tongues they presented the strawberry appearance peculiar to scarlet fever. Afterward the desquamation became general. The source of infection was traced to the nurse, who had two scarlet-fever wards under her charge.—*British Med. Jour.*, March, 25, 1882, p. 422.

Case of mild scarlatina complicated with rheumatism.—The following interesting case is reported Dr. J. A. WILLIAMS, of the London Hospital: A young medical man, with family

history of rheumatism, and subject to rheumatic pains, but never having had acute arthritis or scarlet fever, complained of general malaise, loss of appetite, headache, sore throat, chills, and also slight stiffness of the wrist joints, accompanied by swelling. His face was flushed and his eyes suffused. Temperature 102.6° . Tongue red and furred; fauces and tonsils intensely congested and swollen. No skin eruption. Quinine was administered. The throat was frequently painted with a mixture containing tincture of the perchloride of iron and glycerine, and he was also given a hot bath. The same evening there was great stiffness and tenderness of the joints, and the next morning the knees, ankles, and smaller joints of the hands were acutely inflamed, and contained a small amount of fluid. The skin over the affected joints presented a scarlatiniform appearance, being made up of numerous punctiform red points, not coalescing, and confined to the skin in the immediate vicinity of the joints; it did not exist over the ankle, knee, or wrist joints, nor could it be seen on the face, neck, or trunk. There was an abundant offensive perspiration from the skin. Urine albuminous. Condition of the throat about the same. Temperature 102° . The temperature and the swelling of the joints was reduced in twelve hours, by the administration of salicylate of soda, and alkalies. The skin eruption disappeared in about two days. This was followed in a short time by a general desquamation of the skin.—*British Med. Journal*, July 1, 1882, p. 14.

Coexistence of scarlatina and vaccinia in the same subject.—The simultaneous development of two eruptive fevers in the same individual has been doubted by the most eminent clinicians, while others, such as Roger and Bergeron, on the other hand, have claimed to have demonstrated its possibility. Dr. FABRE publishes a report of a case, which confirms the latter opinion, in which scarlatina developed on the twelfth day of vaccinia, and pursued a normal course. The two exanthemata developed simultaneously in the same subject, and furnish, therefore, an incontestable refutation of the theory of the incompatibility of simultaneous morbid processes as originally maintained by Hunter.—*L'union méd.*, April 30, 1882; *Medical News*, Phila., 1882, June 24, p. 687.

The etiology of scarlatina.—Dr. EKLUND, of Stockholm, in studying the etiology of scarlatina has arrived at some results which, if confirmed by other observers, will be of the highest practical importance, as solving the connection between bad drainage and other unsanitary conditions and outbreaks of scarlatina produced spontaneously. In the urine of persons suffering from scarlatina he has constantly found a prodigious number of discoid corpuscles, oval or round, their diameter being less than $\frac{1}{100}$ millimetre, or from a thirtieth to a tenth of that of a red blood-cell. They are colorless or yellowish white, surrounded by a distinct

cell-wall, and containing a well-defined nucleus of a deeper hue ; sometimes one or more nucleoli may be seen. They exhibit rotatory or oscillatory movements, especially when a drop of water is added to the fluid. They multiply themselves, as he has frequently observed, by fission, first of the nucleolus, next of the nucleus, and finally of the entire cell. He cannot say whether they develop into a mycelium ; at any rate, the presence of fine filaments seems to be exceptional. He has never seen them adhere in fine moniliform chains or massed as zoöglœa. He considers them to be veritable schizomycetes, and proposes the name of *plax scindens*. Dr. Eklund positively asserts that he has found these identical organisms in vast numbers in the soil and ground-water of the Isle of Skeppsholm, in the mud from the trenches dug for the water mains, and among the greenish moulds of the walls of the old barracks, where scarlatina was most rife. He even says that cases of scarlatina have occurred in children after drinking milk mixed with the ground-water of the island, and cites one case which followed immersion in one of these trenches, and the drying of the child's clothes in a small room. In still another case, scarlatina broke out in a block immediately on the exposure of the ground-water by excavations around.—*Medical Times and Gazette*, London, Jan. 28, 1882 ; *Practitioner*, London, July, 1882, p. 55.

Purpuric small-pox ; a case with autopsy and sequel.—

Dr. GEORGE H. ROHÉ, of Baltimore, reports a very interesting case of hemorrhagic small-pox, which lately came under his notice.

H. F., a rather robust German, stoker on a steamship, was admitted to hospital suffering from true erysipelas. The inflammation was diffused over the head and upper extremities, apparently having its origin in three carbuncular-looking swellings, situated, respectively, on the upper lip, right wrist, and left hand. The carbuncular masses on being opened discharged a considerable amount of pus and necrosed connective tissue. He was given tincture of iron in full doses, and in three days the erysipelatous inflammation had disappeared. On the fourth day there was a renewal of the fever, accompanied by headache, nausea, and vomiting—the latter symptom being attributed to the iron its administration was discontinued. On the afternoon of this day (fourth) a red rash, not elevated, appeared on the face, and by the next morning had spread over nearly all the body. The eruption resembled scarlet fever, being accompanied by redness and swelling of the throat. On the fifth day from the commencement (second day of eruption) small petechial spots were to be seen on the body, especially the abdomen and extensor surfaces of the arms. The headache and vomiting continued, but there was no pain in the back. On the next day (third day of eruption) the petechiæ became more general, the spots in some places coalescing to form large brown patches, which did not disappear on

pressure. At this time a few disseminated, small, conical papules were observed on the inner anterior aspect of the thighs, which were supposed to be lichen pilaris. Free perspiration was also noticed. He was seized with violent pain in the lumbar region, on this day (the third of the eruption), and died about 3 P. M., his mental faculties remaining unimpaired.

On post-mortem examination the surface of the body was found to be covered with petechiæ, being in large numbers on the chest, neck, extensor surfaces of the arms, and on the scrotum. In these localities they became confluent, forming large brown patches, which did not disappear on pressure. There were some papules on the thighs resembling closely lichen pilaris. All the tissues and organs of the thorax were found to be infiltrated with a bloody serum; their color was darker, and marked by hemorrhagic infarctions in places. About two ounces of bloody serum was found in the peritoneum. Recent pleuritic adhesions were found on the right side. Lungs oedematous, the right being adherent at the apex. Heart empty, soft, and flabby, and of dark red color. Omentum of a rusty color from infiltration of blood. Liver slightly enlarged, and softer than natural. Spleen about four times its normal size, also dark in color and soft. The kidneys were about twice their natural size, with ecchymotic spots in the tissue of the capsule, and effusions of blood underneath the latter. The surface of the right kidney presented disseminated ecchymotic spots similar to those on the surface of the body, and a large clot was found in the lower part of the capsule. Disseminated ecchymoses were found on the mucous coat of the stomach; a large subserous clot of the duodenum extending about one and a half inches from the pyloric extremity, was also found. The bladder contained a small quantity of bloody urine, otherwise it was healthy. The right temporal muscle was permeated by blood, which also appeared in closely disseminated spots throughout the other muscles of the scalp. The dura mater was slightly thickened, and the pia mater somewhat congested. The brain appeared normal, with the exception of some hypostatic congestion in the occipital region. The spinal cord was not examined. On examining the arm a good vaccination scar was found, and it was supposed that the purpuric condition was due to blood poisoning caused by the erysipelas.

On April 2, twelve days after the autopsy, one of the physicians assisting Dr. Rohé became indisposed and developed a high fever, accompanied by diffuse redness of the body, less marked on the face than elsewhere. The next day he complained of pain in the back, and knees, and the temperature rose to 105.5°; pulse, 130. On the 4th there was less redness, and a few papules were scattered over the body. At this time the diagnosis of small-pox was made. Other undoubted cases of small-pox developed afterward, and it was also discovered that others of the passengers were attacked with the disease. The case is given by Rohé as it presents many features which are different from the appearances generally

seen, such as enlargement of the various organs of the body. Also in purpuric variola the redness generally appears on the trunk and body, leaving the face free. There was also an absence of bloody stools or mental derangement.—*Medical News*, Philadelphia, July 1, 1882, p. 3.

The value of the number of vaccinal cicatrices in the prognosis of small-pox.—LANDRIEUX, in a communication to the Société Médicale des Hôpitaux, on May 26th, says that not only the number but the character of the scars must be taken into consideration in making a prognosis of small-pox, and divides the scars into genuine and spurious cicatrices. In seventy-one cases of variola, with more than three genuine scars, three died, or 4 per cent., while in ninety-eight cases, with three or less genuine scars, twelve died, or 12.24 per cent.; of 143 cases with more than three superficial scars, twenty-nine died, or 20 per cent.; of 133 cases with three or less superficial scars, thirty-one died, or 23 per cent. It is therefore seen that the number and character of the scars in a case of variola will serve as an accurate guide for forming a prognosis.—*Gaz. hebdom.*, June 2, 1882; *Medical News*, Philadelphia, July 8, 1882, p. 38.

Small-pox and vaccination.—The following cases may prove of interest because of the great outcry made by some against vaccination. They are reported by GREENWOOD.

A woman suffering from small-pox, suckled her child throughout nearly the whole period of the disease. The latter, vaccinated successfully a month before, never showed any symptoms.

Small-pox occurred in a German family, and the oldest of four children finally died of it. He was the only one of the family unvaccinated.

Small-pox broke out in a family of three children. On the removal of the oldest, aged seven, to the hospital, the other two were vaccinated, though the mother said that the second child, aged five, was not feeling very well at the time. The vaccination was successful in both cases; but in the second child, as the vaccine pustules were beginning to die away, just ten days after vaccination, a slight but distinct variolous eruption broke out over the body. The unvaccinated child died of the disease: the other showed scarcely any constitutional symptom; the vaccine, owing to its shorter period of incubation and action, having anticipated the action of the variolous poison which was already in the system.—*British Medical Journal*; *Louisville Med. News*, March 4, 1882, p. 107.

Antiseptic vaccine lymph.—POTT has instituted a series of vaccination experiments, using lymph, diluted with various antiseptics. These were solutions of salicylic acid, one part in three hundred; boracic acid, three and a half parts in one hundred; and carbolic acid, one to five parts in one hundred. The lymph was active in all the solutions except that containing 5 per cent. carbolic

acid. No disadvantages of any kind were observed. The following advantages are claimed: the lymph is more fluid and more readily worked with; it can in all probability be kept in an active state for a number of years; if the lymph contain "erysipelas poison" the antiseptic solution will probably neutralize it. This is of course assuming that a solution which does not affect the vaccine (micrococci?) is active enough to kill the erysipelas germs.—*Fuhrbuch f. Kinderheilk.*, 1881; *Schweiz. Corres.-blatt*, Dec., 1881; *Practitioner*, London, July, 1882, p. 60.

Impure vaccination and puerperal fever.—Dr. DEEMER, of Manorville, Penn., reports the following cases: On January 26, 1882, he was called to see five children suffering from erysipelatos inflammation caused by vaccination with humanized virus. Two days after, a girl aged twenty-one years, who had been vaccinated from the same scab, died of septicæmia. Six or seven other children vaccinated from the same source also passed through severe forms of blood poisoning, but recovered. On February 4th Dr. D. was called to attend a Mrs. S. M——, aged forty-two, suffering from puerperal fever, and who had been confined on February 1st. She died a week after. During labor, she had been attended by a woman coming from the dead girl's house. The second case was the mother of the children mentioned as being first vaccinated. On February 16th normal labor occurred. She was attended by the same midwife. On the same night puerperal fever set in, and she died on the next day. D. thinks that both deaths were primarily due to impure lymph.—*Medical Record*, N. Y., Aug. 12, 1882, p. 196.

Etiology of hemorrhagic variola.—At the Rochelle Congress, Dr. PERTIT read a paper on this subject, in which he came to the conclusion that the visceral alterations found at the autopsy of individuals dying of the disease should be regarded as the causes, rather than the effects, of this form of small-pox. The same may be said of other forms (usually termed malignant) of this and some other affections. It is necessary, however, to distinguish between two forms of the alterations observed, viz.: those which are of old date, as degeneration, steatosis, sclerosis, etc.; and those of recent origin, as interstitial hemorrhages. Visceral lesions, whether causes or effects of a morbid condition of the economy, act on variola as they do on traumatic lesions, by imparting modifications to the blood or tissues, and especially the capillaries. Among the subjects predisposed to hemorrhagic variola may be ranged those who have already suffered from diseases of the liver, spleen, kidneys, heart, and perhaps lungs, or from affections capable of producing serious change in these viscera, as rheumatism, scarlatina, paludism, alcoholism, pregnancy, etc. Although we may not be able to point to any therapeutical advantage derivable from these etiological conclusions, they may aid our prognosis when individuals, the subject of these conditions, contract small-pox. Such

cases will very probably exhibit the hemorrhagic form, or even some other still more serious one.—*Gaz. des hôpit.*, Paris, Sept. 5, 1882 ; *Med. Times & Gazette*, London, Sept. 23, 1882 ; *Medical News*, Phila., Oct. 14, 1882, p. 432.

Salicylate of soda in variola.—Dr. BAUDON has obtained good results from the use of this drug in three cases of small-pox. The first case occurred in an old man, aged seventy-two years, vaccinated when a child. The disease was of the confluent form. The suppuration was abundant, and to guard against the whole system being infected, the face and greater part of the body were anointed thrice daily with the following : \mathbb{R} Sodæ salicylat., 3 j ; Ung. aq. rosæ, \mathfrak{z} j ; \mathbb{M} . Besides, the whole surface was dusted over with : \mathbb{R} Acidi salicylici, 3 iss ; talc, \mathfrak{z} iij ; \mathbb{M} . The result was that no pus was formed and no odor developed. The parts not covered with either ointment or powder underwent slight suppuration. B. believes that this treatment averted serious impending results, as well as danger to the attendants. Two other cases were similarly treated. In the last case, the following mixture was given besides : \mathbb{R} Sodæ salicylat., 3 j ; syrupi, 3 viiss ; aquæ dest., \mathfrak{z} iv ; \mathbb{M} . Teaspoonful in water.—*Bull. gen. de thérap.* ; *Med. and Surg. Reporter*, Philadelphia, April 1, 1882, p. 353.

Abortive treatment of erysipelas faciei.—NORREGARD has several times checked the progress of facial erysipelas by drawing a thick ring of collodion around the affected part, not over the whole surface as by others. Dr. Christie mentions a similar case in which the swollen skin bulged over the ring without being able to pass the barrier. The ring must be strong, especially on the bearded portion of the face.—Abstracted by Dr. H. J. Garrigues, from *Norsk. mag. f. læger*, vol. x, p. 379 ; *Nordisk. med. Arch.*, vol. xii, No. 27, p. 13.

Erysipelas propagated throughout the digestive tube.—An interesting case of erysipelas is reported by RENDU. The disease commenced on the left cheek, on the site of an acne papule, and spread through the whole extent of the alimentary canal. There was swelling of the lips and tongue, together with dysphagia and angina, indicating the propagation of the cutaneous affection ; and on the mucous membrane of the cheeks and lips the lesion presented the same characters as on the skin. On the next day there was nausea and vomiting, showing that the stomach had become affected ; on the following day symptoms of enteritis were present, viz. : excessive tympanitis, colic, and profuse and fetid diarrhœa. This tympanitis and diarrhœa persisted with alarming intensity for five days, and did not begin to decrease until the end of a week. It was then that sharp pains, perineal swelling, and all the symptoms of a phlegmon appeared. In three or four days an abscess accordingly formed at the margin of the anus. Considering this in connection with the appearance later

of a submental cervical abscess, the author concluded that intestinal erysipelas had existed.—*La France médicale ; Med. Record*, N. Y., Oct. 14, 1882, p. 434.

The external use of iodine in erysipelas.—A great deal has been said of late on the value of tincture of iodine in erysipelas, and to prove its efficacy, Dr. TOMKINS, of Manchester, has made use of it extensively since 1878, having treated more than three hundred cases of the disease with this agent. He is so thoroughly convinced of its superiority over other remedies that he uses it almost exclusively. T. thinks that probably the action of iodine in erysipelas is due to its antiseptic and germicidal properties, or else it is because of the astringent action upon the capillaries. T. also speaks highly of the application of the tincture of iodine in variola, allaying, as it does, the itching, fetor, and hastening the drying of the pustules.

In connection with this subject, a case occurring in the practice of Dr. C. F. HUTCHINSON, of Scarborough, may be noted. The patient, a robust man, was attacked with idiopathic erysipelas. Iron and the usual internal remedies had been given. When seen by H. he was unconscious, rambling, and supposed to be in a moribund state. The hair was immediately cut, and the scalp painted with tincture of iodine. At the same time the amount of iron was increased, and forty minims of spirit of chloroform added to each dose. On the second day he was out of danger, and never has had any return of the disease.—*British Medical Journal*, Aug. 5, 1882, p. 209 ; Sept. 30, 1882, p. 632.

(Recent Literature reserved for want of space.)

NEUROSES AND HEMORRHAGES.

GORHAM BACON, M.D.

Peliosis rheumatica.—The two following cases of this disease are recorded by McNAUGHT and were under his care.

The first patient, a little girl, æt. six years, was seen Apr. 10, 1881. For the last fortnight, the mother said, small red spots had appeared over the legs and thighs and gradually died away in two or three days, only to be succeeded by fresh ones. There had been considerable pain and stiffness in the legs, accompanied by fever. When seen for the first time, she was confined to bed, unable to walk, with pain in the knee-joints, which were somewhat swollen. Skin hot : numerous purplish spots, from the size of a pin's head to that of a sixpence, were found, scattered over the legs, thighs, and buttocks ; unchanged by pressure. There were no spots higher than the hips, and the gums were normal. In about four days this eruption had disappeared and had undergone the varying tints usual to a bruise. These spots were suc-

ceeded by a fresh number, more raised and unaffected by pressure, and they extended now over the arms as well as the legs. Child was pale and anæmic, and had a systolic murmur heard at the apex. For some weeks the case pursued a similar course, the spots fading in about four days, to be followed by a fresh crop. Treatment seemed to have but little influence on the disease, as the liquid extract of ergot was first used to no effect, together with stimulants and nutritious diet, and then changed to iron and quinine. At the end of about three months the disease had disappeared, independently of treatment.

The second case was that of a male, æt. eighteen months, first seen March, 1881. He was in a delicate condition, having recently suffered from teething, irritation, and bronchitis. The mother stated that when she put the child to bed, she noticed nothing peculiar about it, but in the morning found that the pillow was much stained with blood, apparently from the nose and face; one side of the face and eyelid was of a deep black color, and enormously swollen; the other eyelid was discolored, but to a less extent. There were three punctiform ecchymoses on the tip of the tongue, and also a few scattered over the scalp and lower extremities, by no means numerous nor of large size. They were unchanged by pressure. There was considerable sponginess of the gums below the front teeth; the child was very restless and feverish. Some improvement followed the administration of the liquid extract of ergot. Severe epistaxis occurred on the third day, and on the following night death took place suddenly, probably due to extravasation into the lungs. This case was undoubtedly one of purpura hæmorrhagica. The points of interest are the early age of the patient, the sponginess of the gums, usually said to be absent in purpura, and the sudden death.—*British Med. Journal*, Apr. 22, 1882.

Peliosis rheumatica.—At the Harveian Society Dr. STEPHEN MACKENZIE read a paper on this subject. He said that the disease was variously regarded by different writers, but it had characters sufficiently distinctive to separate it from other forms of purpura. According to his experience, the disease occurs more frequently in women than in men. It is generally stated to be most common between the age of twenty and thirty, but he had seen several cases occurring under twenty. One peculiarity of the disease is that the purpuric spots generally appear in the afternoon or evening, often with great regularity, sometimes each day, sometimes at intervals of several days, accompanied by pain and stiffness and occasionally swelling of the joints. When first seen the spots are bright, but the next day become purple. The eruption is generally found on the extremities, and when occurring on one extremity, upper or lower, it will generally be found on the other. There are no profuse sweats generally unless the attack occurs with rheumatic fever. The attacks are liable to recur and are generally protracted, extending over some months at

times. The disease gradually wore itself out, not yielding to any particular plan of treatment, but sometimes was influenced by the administration of salicylate of soda, sometimes by quinine and ergot. The following cases were mentioned :

1. A lad, æt. eighteen, had one attack of rheumatic fever ; had heart disease. The present was the fourth attack. The purpuric spots were found on the arms and legs, and moderate arthritis and pyrexia existed. The outbursts of the eruption were frequent, and always occurred in the evening. The attack covered the period of ten weeks.

2. A woman, æt. twenty-seven, developed rheumatic fever, and purpuric spots appeared on the trunk and lower extremities. There were several crops of the eruption, and the attack lasted ten days.

3. In the case of a middle-aged woman, who had previously had acute rheumatism, the purpura was accompanied by a certain degree of erythema, and the attacks occurred each afternoon.

4. A girl, æt. thirteen, had the disease for ten months, the attacks always occurring in the evening.—*Lancet*, March 18, 1882.

Blood-discs in a case of hæmorrhagic diathesis.—

JAGO had a patient under observation for some years, who was subject to attacks of prolonged bleeding from the slightest cut or scratch. Finally he became subject to frequent and very obstinate hemorrhage from the nose. Treatment was of little avail, as the dribbling of blood from the nostrils would continue for days. Death finally occurred from exhaustion. A microscopical examination showed that the blood-discs, though normal in diameter, were extremely thin, being not more than half the thickness of the normal ones, and the central depression of the ordinary disc was detected with difficulty. The thinning was evidently at the circumference of the blood-corpuscle.—*British Medical Journal*, April 22, 1882.

Scurvy.—SCHWATKA during 1878-79, while in the Arctic regions, came in contact with a great deal of scurvy. The principal cause of this disease is the want of fresh meats, fruits, and vegetables, in addition to damp quarters, exposure to the depressing effect of the long-continued polar night ; while in poorly conducted expeditions are superadded poor ventilation, illy-cooked food, and lack of sufficient exercise for both body and mind. None of these auxiliaries are capable within themselves of producing the disease until the vital forces have been lowered by continued abstinence from fresh foods. Sir John Ross thought that a want of fresh bread was a cause, but in Schwatka's party there was no fresh bread eaten during a period of two years, and for nearly a year they were without any. One of the greatest obstacles in the employment of fresh animal food, is the antipathy with which such a diet of fish-eating animals is received by the consumers. The flesh of the reindeer is very palatable, but that of the walrus and polar bear have peculiar flavors, which it

is very difficult to overcome. It has been supposed that dampness was a prime cause, but in most of the whale-ships, where the disease occurred, there was no dampness. It is, however, a powerful ally to the principal cause, and should be guarded against, but undoubtedly too much stress has been laid upon this factor. Again it is said by high authorities that the disease occurs through a want of vegetables and fruits, and that the anti-scorbutic virtue of such depends on the presence of the salts of potassa. "The true virtues of vegetables are to be found in the freshness of their condition, and the efficacy of saline medication is well shown in the simple laws of assimilation." From all the conflicting theories, the most satisfactory explanation seems to be "that it is in some unknown vital principle that the anti-scorbutic properties reside, a statement that is further supported by the fact that raw and unripe potatoes, cabbage, fruits, etc., *i. e.*, when they are at their very maximum of vitality, are known to be more efficacious as prophylactic or curative agents than at any other time, although they are far less digestible at this time than when ripe." The same can be said of animal food. To drink the warm blood of a freshly-killed animal is a popular remedy in the Arctic regions. Raw meat is superior to cooked. Some advance the theory that a too restricted animal diet may develop scurvy, but the Esquimaux are not only carnivorous but eat their meat mostly in a raw state.

The only anti-scorbutic remedies are fresh foods (this includes any thing recently deprived of life, or having the power of preservation of the living principle to an eminent degree). Early voyagers found the foliage of the spruce pine efficacious; also sorrel and the scurvy grass of the Arctic are prophylactic.

The most efficient fruits and vegetables are those simply dried by atmospheric exposure, as boiling, burning, and violent chemical action, if used to preserve food, seem to destroy its vitality and take away its anti-scorbutic properties. Finally, "scurvy has but one prime essential causation, and but one specific cure: the want on the one hand and the ample supply on the other of fresh, vitalizing nourishment."—*Medical Record*, N. Y., Sept. 23, 1882.

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EXUDATIVE OR INFLAMMATORY AFFECTIONS :
MULTIFORM, SQUAMOUS, PHLEGMONOUS,
AND ULCERATIVE.

W. T. ALEXANDER, M.D.

On the treatment of eczema by Bantingism.—B. SQUIRE advises in eczema occurring in lymphatic fat young children to limit the supply of the fat-producing elements of the food. Milk should not be taken pure, but diluted one half or more with water. In place of bread and butter, dry toast or biscuits should be given. All fat should be removed from meat, and pork, veal, or lamb should be forbidden. Beef tea and toast-water may be

freely used, and cooked, unsweetened fruit. Cod-liver oil must of course be abstained from. By using this diet, S. has found that the excessive obesity of the children is much diminished and their eczema remarkably benefited within ten days, and without injury to their general health.—*British Medical Journal*, April 8, 1882, p. 499.

On the *viola tricolor* (L.) and its uses in eczema.—PIFFARD gives the botanical description, the therapeutical history, and the results of his own experiments with this drug, the pansy. He first tried the infusion of the dried herb, the mother tincture (homœopathic), and a solid aqueous extract, from all of which he obtained greatly varied results, sometimes brilliant, sometimes negative, in apparently similar cases. He then made a special importation of the drug, from which he had a fluid extract made, which preparation (made by Squibb) has proved in every way satisfactory. He then gives the chemistry and physiological action of the drug, instituting a comparison between its action and that of salicylic acid, which it has been proved to contain, and finds them strikingly alike. In his therapeutic observations he states that he has repeatedly witnessed the increase of the eruption of eczema after full doses of the drug, as described by older authors, which usually begins in from three to six days after commencing its use. This sometimes subsides even during a continuance of the medicine, and recovery rapidly ensues. If the drug is stopped, the eruption decreases, and the patient becomes much better or entirely well, although a second or third course of the treatment is sometimes necessary. For young children with *acute* eczema (in order to avoid this drug aggravation of the disease), the proper quantity to begin with is one to five drops of the fluid extract (Squibb's) once or twice a day, to be maintained, diminished, or increased according to the progress of the case. In the subacute or chronic forms of the disease, the commencing dose should be larger, ten or fifteen drops at least, and in adults from half a drachm to two drachms in subacute cases. The dose should always be taken in water, always on an empty stomach, about half an hour before meals.

His best results have been obtained in the second stage of eczema with sero-purulent exudation and crusting. In the third stage other remedies appear to answer as well, if not better.

He then enters into a discussion of the theory of the action of the drug, and concludes that it is neither antipathic, homœopathic, nor allopathic, but specific; and concludes his interesting paper by stating two problems as worthy of investigation: "Will salicylic acid prove itself as useful in eczema as *viola*?" and "Will *viola* prove useful in rheumatism?"—*Medical Record*, N. Y., April 29, 1882, p. 449.

***Viola tricolor* in a case of chronic eczema.**—J. FERGUSON reports a case of chronic eczema of the face, in which the skin was very thick, much infiltrated, and deeply fissured in many

places, the patient suffering greatly from itching and burning. The disease was of long standing, and the skin dry and scaly. Other methods of treatment having failed, the patient was directed to use daily an infusion of *viola tricolor* made by steeping two drachms in ten ounces of water. All local treatment was suspended. In a week the skin began to discharge a large quantity of serum, and there was more inflammatory action than before. The drug was then discontinued, and a mild saline diuretic ordered. In a few days the *viola tricolor* was resumed in smaller doses, about forty grains daily, in infusion. This was continued six weeks, at the end of which time the patient's general health had much improved, and the appearance of the skin was very favorable, the patient sleeping well and enjoying a degree of comfort unknown for several years.—*Canadian Journal Med. Sciences*, April, 1882, p. 110.

Local syncope of the extremities, eczema of the palms of the hands and fingers.—LELOIR and MERKLEN, to show that eczema may sometimes have a purely nervous origin, report the case of a woman arrived at the menopause, suffering from peripheral nervous troubles, consisting in neuralgic pains radiating along the principal nerve-trunks of the forearms, attacks of "local syncope" of the extremities, "periungual panaritii," and dry scaly eczema of the palms of the hands, the fingers, and nails. The coincidence of these various phenomena, their localization and symmetry, allow them to be ascribed to one general cause, an ill-definable nervous irritation, hard to localize, but demonstrable by its effects, and probably due to the physiological disturbance produced by the menopause. (In the attacks of "syncope," which occurred frequently, the fingers became suddenly cold and livid, and the patient experienced a sensation of numbness in the extremities and ears.) She finally recovered entirely by the use of arsenic and iodide of potassium.—*Annales de dermat. et syphilis*, Paris, 1882, tome iii, No. 6, p. 351.

On the use of chrysophanic acid internally in psoriasis.—ALEXANDER NAPIER first details the unpleasant effects produced by the external use of this agent, and claims that it has a constitutional as well as a local action. In proof of its absorption by the skin he cites the experiments of Lewin and Rosenthal, who found that when ointments of chrysarobin were rubbed into the skin of rabbits the drug was absorbed and partly oxidized into chrysophanic acid, while the part that was not so oxidized excited violent nephritis in being eliminated by the kidneys. He then reports three cases in which the internal use of the drug caused the disappearance of psoriasis. In the first case he began with one eighth of a grain of the drug in powder with sugar of milk, three times a day, and increased the dose gradually until after four months of the treatment the patient took two grains three times a day, without the occurrence of any signs of irritation of the stomach and bowels, and with entire disappearance of the eruption.

During the treatment the patient had no conjunctivitis, and there was no change in the color of the hair or urine.

In the second case, one grain and a half after each meal caused vomiting, and the disease finally slowly yielded to one quarter of a grain in powder, *ter in die*. In the third case the patient was lost to observation before the cure was complete.

After cure he always found that the spots showed the same unnatural paleness as after the use of the drug in the form of ointments. He suggests half a grain as a good medium dose for an adult to start with, to be gradually increased as the stomach is able to bear it. It seems to be better borne when given in powder with sugar of milk after meals, a pill with extract of hyoscyamus causing much greater disturbance.—*Lancet*, London, May 20, 1882, p. 817.

Large doses of iodide of potassium, especially in psoriasis.—GREVE recommends large doses of iodide of potassium in skin diseases, especially psoriasis. He begins with a mixture of iodide of potassium, 10.00 to 300.00 water, of which he gives a tablespoonful three or four times a day. Every time the prescription is renewed five grammes are added. He always increases the strength to 30.00 iodide to 300.00 water, and has, without inconvenience, given as high as 40.00 to 300.00. As soon as the dose of one gramme is reached, an effect is produced on the skin lesion. If the dose is limited to one gramme or one and a half, the improvement is gradual, but if the amount is increased to 2.00 or 2.50 grammes, the improvement is rather rapid. The less affected parts of the face are first cured; next, the eruption on the neck, chest, and back disappears; and last on the extremities, where shining cicatrices often remain because of thickness of the parts. Greve has given the drug both to adults and children and never seen any injurious effect from its administration.—Translated by H. J. Garrigues from *Nordisk medicinskt Archiv*, vol. xiv, No. 1, 1882.

A method of preventing the development of scars and contractions in burns, by glycerine.—GUZZO recommends that burns be treated as follows: a pledget thickly spread with cold cream should be applied over the whole surface, and upon this a mass of cotton wadding, or a compress at least one or two inches thick, should be laid and kept saturated with glycerine pure or diluted with water, the whole being covered with a dry compress and a bandage. The cotton must be freshly moistened with glycerine three to six times daily, and the whole dressing changed every twenty-four hours. In only one case of bad burn out of fifty-two under his care, which he treated in this manner, did extensive cicatrization ensue.—*Gaillard's Med. Journal*, March, 1882, p. 217.

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II.

SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUTICS, ETC.

ARTHUR VAN HARLINGEN, M.D.

Late lesions of syphilis appearing in the locality of former wounds.—MALÈCOT quotes his master, Verneuil, to the effect that a traumatic process once terminated, no further change takes place. For this reason, when a new morbid process appears in the site of a former one, some new cause has operated : a new wound, an accidental contamination, the application of some physical or chemical agent, etc. When careful examination shows no sign of local morbid action, it may be asserted that the entire economy has been invaded by some constitutional perversion, which expends itself in the old locality as a place of least resistance.

To illustrate this as regards syphilis, Malècot gives notes of several cases coming under his observation.

The first of these concerned a man twenty-five years of age, in whom a scar of eleven years' standing over the tibia, following an

osteo-periostitis, opened soon after the appearance of a chancre (genital?) The ulcer differed from the ordinary ulcer of periostitis. When seen by Malècot it had lasted about three months, the patient showing mucous patches about the mouth. Its borders were sharply excavated, coppery-red in color, and the sore secreted a sanious pus. There was no involvement of the bone. A new ulcer had appeared just below the old one a few weeks previously. The lesions were both painless. Under the use of protoiodide of mercury the ulcers healed rapidly.

The second case was that of a young man of twenty, who had suffered from a comminuted fracture at the elbow-joint at three years of age, which resulted in deformity and restrained movements, but had never given pain. Seven weeks after the appearance of a genital chancre the joint became swollen and inflamed, and all movement was prevented (arthritis?).

In a third case, a bruise sustained by a person in full evolution of syphilis was followed by sphacelus and the formation of a characteristic ulcer.—*Annales de dermatologie et de syphiligraphie*, t. iii, n. s., p. 228.

Dactylitis syphilitica.—Dr. W. G. PORTER reports the case of a boy five years of age, with a history of sore eyes and sores over the scalp at two years of age, who, when examined, was found to be suffering from extreme enlargement of the cervical glands with resultant dyspnœa, and also enlargement of the first metacarpophalangeal joint and phalanx (which finger not stated). As the enlargement went on the color of the member changed to a violet or purplish hue, but no pain was experienced. The swelling extended gradually to the second phalangeal and to the carpo-metacarpal joints. When examined by Dr. Porter the metacarpophalangeal joint measured five inches in circumference. There was no crepitation in the joints and their movements were normal, except in so far as the hypertrophied tissues surrounding prevented perfect motion. Suppuration had taken place several times (when?). The child was placed upon the $\frac{1}{64}$ grain bi-chloride of mercury in tincture of cinchona thrice daily. No improvement was noted while under observation, but also no retrogression.—*Philadelphia Medical News*, March 18, 1882.

Excision of the initial lesion of syphilis.—Dr. C. F. BEVAN reports eight successful cases, as follows:

CASE 1.—Sore on the extremity of a redundant prepuce, appearing twenty-one days after connection, and showing characteristic features. No glandular enlargement. Confrontation showed mucous patches on the woman's vagina. Circumcision. No generalized syphilitic lesions during two years' observation.

CASE 2.—Sore on prepuce appearing twenty-one days after connection with a woman suffering with a pustular syphiloderm. Enlarged inguinal glands. Circumcision three days after appearance of sore. No subsequent symptoms found on examination and interrogation of the patient two years later.

CASE 3.—Sore on the extremity of a long prepuce with enlarged inguinal glands appearing twenty-four days after exposure. Circumcision. Frequent examination of the patient during two years showed freedom from generalized symptoms.

CASE 4.—Sore on side of prepuce, appearing seventeen days after exposure. Slight glandular enlargement. Confrontation showed a labial ulcer on the woman, followed by a papular syphide. Excision. No generalized symptoms in eighteen months.

CASE 5.—Sore on the frenum appearing fifteen days after contagion. Inguinal glands slightly enlarged. Excision was practised three days after the appearance of the sore. The patient remained free from syphilis at the end of eighteen months. A comrade who visited the same woman, and about the same time, suffered with generalized syphilis subsequently.

CASE 6.—A sore on the extremity of the prepuce occurring twenty-one days from the last previous exposure, and accompanied by enlarged inguinal glands, was excised thirty-six hours after its appearance. No generalized symptoms were observed within a year.

CASE 7.—Sore of side of penis appearing seventeen days after last previous exposure. No enlargement of inguinal glands. Excision about five days after its appearance. No subsequent symptoms of syphilis during nine months' observation.

CASE 8.—Sore of extremity of "congenitally phymosed penis" (prepuce?) appearing twenty-one days after the only exposure. Enlargement of inguinal glands. Confrontation showed the woman to have vaginal lesions of syphilis. Excision about two days after appearance of sore. No generalized lesions in the year following.—*Maryland Medical Journal*, Balt., 1882-3, ix, p. 1.

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SYPHILIS OF THE EYE AND EAR.

EDWARD S. PECK, M.D.

Lesions of the orbital walls and contents, due to syphilis.—C. S. BULL, in a valuable paper read before the N. Y. Academy of Medicine, considers the syphilitic diseases of the bones forming the walls of the orbit, and of the connective and adipose tissue of the orbital cavity, without reference to those of the eyeball or of the adnexa. (See paper in *N. Y. Medical Journal*, April, 1882, p. 360, for description of his and one other case of syphilitic diseases of the lachrymal gland.) Disease of the bony walls of the orbit, he remarks, is not a very common manifestation of constitutional syphilis, though it is by no means rare. The lesions are: 1st, a periostitis or osteo-periostitis, with or without subperiosteal abscess; 2d, gummy tumor or syphiloma of the periosteum; 3d, periostosis, hyperostosis, or exostosis of one or more bones; and, 4th, caries and necrosis, involving more or less of the entire thickness of the bony walls. Clinical observation would seem to afford ground for the belief that the bones of the orbit are not so frequently affected by syphilis as other parts of the bony skeleton, but the dead-house teaches a somewhat different story, and he is inclined to think that a more careful and minute examination of the patients in the venereal and surgical wards of our large hospitals would lead us to alter our opinion in regard to the frequency of the occurrence of the bony lesions in this region. Some of the symptoms are slight in severity and transient in duration, and often are not pronounced enough to

attract the attention of any one but the patient. These lesions, according to most authorities, belong to the late stages of syphilitic infection, though the most recent investigations seem to point to the existence of two forms of periosteal disease due to syphilis, which are to be distinguished from each other by the intensity of the process, and the period of constitutional infection at which they occur. It seems to be a recognized fact that the cases of syphilitic osteitis and osteo-periostitis developed during the early or secondary period of constitutional infection are much less severe than those observed later. The latter are accompanied not only by subperiosteal and osseous gummata, but also by dense osteitis and necrosis. In the late, as in the early, osseous symptoms of constitutional syphilis, the exciting cause of the bony lesion and of its location is generally found in contusions, repeated bruising, and slight injuries. Though these various lesions of the bony orbit are generally regarded as late manifestations of constitutional syphilis, yet attention has been called to their by no means very rare occurrence as an early lesion, and this is particularly the case with periostitis of the orbit. Perhaps the most interesting cases of syphilitic orbital disease to the clinical observer are, he adds, those which present the results of chronic hyperplastic bone disease, such as periostosis, hyperostosis, and exostosis, both on account of their rarity and of the possible resulting deformity. There seems to be still some doubt as to the pathogenesis of periostosis, pathologists being divided in opinion as to whether it is the natural result of a plastic periostitis, or whether it is a distinct pathological process in itself. It is certainly a rare process in the orbit, where periostitis syphilitica usually either yields to treatment and leaves no trace of its presence, or else ends in suppuration and caries. Periostosis here is probably a chronic periostitis which has ended in induration or sclerosis, forming a tumor, more or less circumscribed, along the orbital margin, and very rarely occurring in the deeper parts of the orbital cavity. Ricord believes in the existence of three kinds of periostosis—inflammatory, gummy, and plastic, of which the last is probably merely a stage of the first. He cites but one case of the gummy variety, occurring deep in the orbit on the nasal side, and which was probably nothing more than a periostitis with the formation of a subperiosteal gumma. It is probable that the process is simply a thickening of the periosteum, and that the term node would apply equally well to circumscribed periostoses of the orbit, as in other parts of the body. They never occur as precocious lesions of syphilis, but are late manifestations, the result of long-continued plastic inflammation, originating, probably, in the periosteum and confined to it, and only in isolated cases ending in ossification. They are generally sensitive to pressure, and painful at certain periods of the day. If they happen to occur in the vicinity of the supra-orbital or infra-orbital foramina, there is more or less trifacial neuralgia all the time, which increases in severity as the periostosis spreads. Though rare under any

circumstances, and almost always observed along the orbital margins, it is probable that they occur deep in the orbit, at or near the apex, and around the optic foramen, oftener than we have supposed. It is probable that many of the cases of paralysis, partial or complete, of one or more of the extrinsic muscles of the eye, coming on somewhat gradually, are due to a periosteal node pressing on the muscle or its nerve branch in its course or near its origin, producing at first paresis and then paralysis by direct pressure as it grows. Such a node, growing from the periosteum at the extreme bottom of the orbit, might, if of any size, easily involve the origins of all the straight muscles of the eye, and this without any very great projection into the cavity of the orbit. Of course in such an instance the optic nerve would probably also be involved, and there would be atrophy of the nerve fibres, perhaps preceded by neuritis descendens. These cases the writer believes are not so very uncommon, and they offer a plausible explanation of the reason why so many cases of paralysis of the ocular muscles in syphilitic patients are not cured by well-directed antisymphilitic treatment. The periosteal thickening goes on gradually, involving the origin of the muscle or its motor nerve branch, until the latter becomes atrophied from compression, and then, although in favorable cases the periostosis may be absorbed by treatment, the mischief has been done and the paralysis is permanent. Another symptom which may be produced by periostosis deep in the orbit is exophthalmus. This form of periostitis, involved in periostosis, does not tend to spread, and hence is but little likely to involve the orbital tissue. Any projection of the eyeball is here due to the periostosis itself. Furthermore, there are no signs of acute inflammation, no constant pain in the orbit, and no sensitiveness to pressure along the orbital margin. On pressing the eye backward, pain is experienced, but the process may go on from the beginning without any pain, and the patient's attention may first be attracted by the exophthalmus, more or less limitation of motility of the eye, then diplopia, or double vision, and finally, impairment of vision. The author treats of various other lesions properly included under the title of his paper, and discusses their pathology and treatment.—*N. Y. Med. Journal and Obstet. Review*, August, 1882.

Syphilitic infection with iritis from an oral chancre.

—DR. CHISOLM, of Baltimore, contributes a case of plastic iritis, which had been treated for catarrhal ophthalmia, coincident with a copper-colored squamous eruption on the forehead, chin, arms, and other parts of the body. Patient was a "modest young lady of eighteen years of age," and was brought by her mother. Two months previous she had had laryngitis and alopecia. Treatment consisted in twenty-five grain doses of salicylate of soda every three hours, and leeches; and tapping the anterior chamber; in addition an eight-grain solution of atropine succeeding in the disruption of the iritic adhesions one by one, until a perfectly di-

lated pupil resulted. From "excessively blurred vision" patient acquired sufficient sight to read *brilliant* type. The syphilitide finally disappeared from the body after the local use of hydrarg. bichlor. in glycerine.

The clinical interest in the case centres in its ætiology. Patient alleged that a "fever blister" appeared five months previously on the lower lip, to the right of the frænum. It was of good size, had a hard base, and occupied six weeks in repair. The hardness persisted for several months. Soon after the lip felt hard, the submaxillary glands became enlarged and painful, and mastication was labored. The eye-affection and syphilitide appeared two months after the initial labial sore. Patient could not remember to have kissed any friend with a sore lip, and was totally at a loss to account for the "fever blister."—*Maryland Medical Journal*, Baltimore, June, 1882, vol. ix, p. 81.

Ocular syphilis and its treatment by mercurial hypodermic injections.—M. GALEZOWSKI prefaces a long article, both clinical and experimental, with a reference to the very unsatisfactory results of all previous treatments of severe forms of ocular syphilis.

Syphilitic disease may exist in all the tunics of the eyeball, but it is especially either an iritis, gummy irido-cyclitis, plastic choroiditis with pigmentation in the retina, optic neuritis, or an atrophy of the disc. It is now fifteen years since G. asserted the impotence of all mercurial preparations administered for ocular syphilis by the digestive tract, and their power when used as frictions. This, at that time, transitional opinion, he re-asserts with some limitations, viz.: that in certain forms of choroiditis, optic neuritis, and atrophy of the disc, dependent upon syphilis, frictions have no power of resolution. Optic nerve atrophy and syphilis so often concur, that it is not easy to determine the dependence of one upon the other. When, however, the syphilitic origin is proven, it too often happens that antisiphilitic treatment has not the slightest happy effect upon the atrophy.

The author then considers the action of hypodermic injections of the albuminate, peptonate, and cyanuret of mercury. The albuminate is prepared from the white of egg, distilled water, and a solution of the sublimate, after the formula of Wurtz. The solution contains a centigramme of sublimate in a gramme of water, or in twenty drops, the size of Pravaz's syringe. In the report of his clinique for 1880-'81, the undoubted advantage of this treatment over all others was shown. The great objection to this salt, and what led to its substitution by the peptonate of mercury, was its facility of coagulation under the skin, and the formation of large and painful nodosities in the cellular tissue. The peptonate was prepared from bichloride of mercury, chloride of sodium, and dry peptones, and the mercurial peptone dissolved in distilled water in such proportion, that the hypodermic syringe, when full, will contain five milligrammes of the sublimate. G. deduced

from experiments with this salt made upon more than fifty patients suffering from different forms of ocular syphilis, that it gave excellent results in affections of the vascular system of the eye, as the various forms of iritis and choroiditis; but that in alterations of the visual nervous system, either peripheric, as the retina or optic nerve, or central, as in cerebral optic neuritis, or in atrophy of the nerve, due to cerebro-spinal syphilis, the mercurial peptonate had no effect. Experiments were made finally with the cyanuret of mercury, with special reference to syphilitic affections of cerebral origin. G. conducted the experiments first on rabbits weighing three to four pounds, by making injections in the dorsal region; a paralysis of all the extremities followed, then a general anæsthesia, diminution in heart-beats, and venous stases in the optic papilla with corneal anæsthesia. At the end of two hours every symptom had disappeared, and the animal returned to his previous habits. Death followed (asphyxia) those same phenomena in an animal of two pounds' weight. G. found in clinical experience that it was necessary to limit the injection of the mercurial cyanuret to five and ten milligrammes at each dose. An increase proved an excess, and provoked diarrhœa with strong colic. More than one thousand injections were given to a large number of patients. As to results, the author states that iritides sometimes with condylomata, or with punctate keratitis, were cured after five, eight, and ten injections, the dose being five to ten milligrammes. Twelve observations are briefly detailed, of which the following cases form an outline: syphilitic iritis with interstitial infiltration of the cornea; iritis with condyloma, with keratitis punctata, and with interstitial keratitis; double irido-choroiditis, double retino-choroiditis, double neuro-retinitis, syphilitic atrophy of the papillæ. The most interesting, if not at the same time the most brilliant, results were obtained in the cases of optic-nerve atrophy. In two cases, detailed more at length than are the others of the catalogue, there were an arrest of the progressive atrophy and a partial return of the ability to detect colors. In one patient, whose chancre was contracted nine years before, the right eye was totally blind, and the left eye counted fingers at fifty cm., or about twenty inches; so that with this eye $v = \frac{1}{1\frac{1}{2}0}$. Daily injections of five, ten, and fifteen milligrammes were given for eight days, when an intermission of eight days was necessitated by colic and diarrhœa. After the twenty-first injection the left eye had $v = \frac{2}{3}0$. As to the chromatopsy, patient could distinguish blue readily, with difficulty yellow, while clear green appeared blue, and red very dark red. In the second patient with syphilitic progressive atrophy of the nerve, the left eye was totally blind; the right showed a diminution of the visual field to within five cm. (two inches) of the fixation point; $v = \frac{4}{3}0$ (central); ability to detect colors. There were debatable evidences of cerebral lesions, but under treatment $v = \frac{4}{1}0$.

These results are worthy of consideration, since the prognosis of optic nerve atrophy (progressive) is very unfavorable.—*Recueil d' ophthalmol.*, Paris, May, 1882, p. 290.

Treatment of ocular syphilis.—M. BLACHEZ contributes a case of recurrent syphilitic iritis with consecutive irido-choroiditis in a wet-nurse, who contracted the disease from a suckling infant, and for which she was successfully treated by injections of one half centigramme of the peptonate of mercury. He reviews the contribution of Galezowski to the French Academy of Medicine in 1869, on the inefficacy of mercurial preparations taken internally for ocular syphilis, as also the earlier contributions of the same author on the topic of the preceding paper of this digest.—*Gaz. hebdom.*, Paris, May, 1882, p. 308.

Inoculation of urethral pus for total pannus.—E. S. PECK reports results of inoculation in six obstinate and exaggerated cases of pannus, as follows: First patient, totally blind in both eyes for several years (right eye eleven, left eye four years); was inoculated with gonorrhœal pus; was discharged in four months at his own request, as he desired to get work; vision in right eye equal to finger-counting at two feet, and in left eye *do.* at ten feet. Patient had had an attendant for some years, and had been most of the time under treatment. His sight has undoubtedly doubled since his discharge from the hospital. Second and third patients had perception of light in one eye, while with the other, each patient counted fingers at one foot. Both were inoculated with a traumatic urethral discharge, which ceased after ten days' treatment of its possessor. A very severe purulent ophthalmia succeeded and continued for seven weeks, during which time both patients had a special nurse night and day; and, though in open ward, they were successfully secluded from the other patients by means of screens. The results of the inoculations were as follow: Second patient: right eye with a previous record of finger-counting at one foot (this eye had a dense central leukoma of the cornea, for which an iridectomy had been made elsewhere); $v = \frac{6}{100}$; left eye with previous record of perception of light; $v = \frac{12}{100}$. Third patient, right eye with previous record of finger-counting at one foot; after inoculation, $v = \frac{20}{100}$, or finger-counting at forty feet; left eye, with previous perception of light, suffered a perforation of the cornea, and was able to count fingers only at two feet.—*Report of the Ophthalmic Division of Charity Hospital*, Blackwell's Island, New York, for 1881, Department Press, 1882.

Palpebral chancre.—M. DELAPERSONNE, of the ophthalmic clinic of Hôtel Dieu, contributes a didactic article on the ætiology, physical characters, symptoms, diagnosis, and treatment of chancre of the lid, with a brief analysis of two cases occurring in the service of M. Panas, Hôtel Dieu, in 1881, and of a case of M. Fournier. Some of the major observations that have from time to time been made by Galezowski, Panas, Ricord, Jullien, Wecker, Desmarres, Mackenzie, and others are referred to for the assistance of the bibliophile in this department of ophthalmic study. While the author does not deny the possibility of a simple chancre

of the lid, he dwells upon its rarity, and emphasizes the only true support such diagnosis can have, viz.: its physical characters, and the absence of secondary symptoms, even several months after the healing of the chancre. The ætiological factors are here, as in the genital sphere, hard to prove. Contagion can be attributed to the projection of saliva, or to fluids charged with syphilitic virus. Patients usually have a ciliary blepharitis antecedent to an ulcer or little ulcerations of the free border of the lid. Phenomena of inflammation are wanting. Patients complain of no pain, nor labor in lid-movements, nor of lachrymation, nor perhaps of deformity.

The physical characters of lid-chancre are variable according to their seat. The most common habitat is the inferior lid, either the cutaneous surface or the free border. As a special adenopathic involvement, the preauricular ganglion takes precedence; after this, the ganglia at the angle of the jaw, and the submaxillary region. It is well known that the lymphatics of the lower lid and inner canthus find their way through the facial vein into the submaxillary and sterno-mastoid ganglia.

When situated at one of the commissures, the chancre takes the form of a fissural ulcer, precisely limited by the free border; on this account the diagnosis may be misconceived, the ulceration being like that following a chronic dacryocystitis. The induration and ganglionic engorgement will prevent the error.

Most rarely the chancre occupies the internal surface of the lid. Inflammatory symptoms are here the most intense, as conjunctivitis, corneal ulceration, and iritis.

After the cicatrization of the chancre, induration persists, even to the concealment of the lachrymal puncta, and their obliteration. Cicatricial bands may unite the two folds of conjunctiva, and constitute a true symblepharon, with results even more serious than the chancre itself.

The diagnosis of lid-chancre is to be eliminated from that of a furuncle, chalazion, lupus, and cancer. The last has an irregular, slightly elevated border, field covered with papillæ, the skin cut out at the circumference, cauliflower in its appearance, and easily bleeds. An invaluable distinctive mark of cancer is the advanced age of the patient, and exceedingly slow march of the sore.

In order to attain the size of a chancre, an epithelioma of the lid sometimes occupies several years.

More difficult is the diagnosis of chancre from lupus, which it most resembles; but the less rapid advance of lupus, its occurrence in young persons, and the absence of lymphatic involvement usually suffice as characteristics of distinction. As a final test of diagnosis, the sore should be inoculated elsewhere on the patient, and the latter be kept under observation several months.

The three cases are then adduced in brief summary.—*Arch. d' ophtal.*, Paris, 1880-1, p. 499.

Syphilitic affections of the eyelids.—Dr. THEODORE WIETHE contributes three cases of lid-syphilis under as many forms, viz. : 1. Initial sclerosis of the lower lid. 2. Ulcerated papule of the upper lid. 3. Gumma of the lower lid. He introduces the statistics of Zeissl, who, among 40,000 cases of syphilis, saw only eight of affections of the lid, and remarks that the oculist meets with but one undoubted case of syphilis of the lid in 10,000 eye-patients. A lengthy description of each case is given, with references by comparison to the cases of Arlt, Hirschler, Desmarres, and Galezowski. Treatment consisted of iodide of potash, inunctions of mercury and iodoform locally : recovery followed in each case. It is worthy of note here, that the microscopical examination of a section of the gumma taken from its groundwork gave swollen fibrillæ of connective tissue.—*Allg. Wiener med. Zeitung*, June 6, 1882, p. 249.

Hard chancre on the conjunctiva of the lower eyelid.—Mr. WHERRY described such a case at the last meeting of the Ophthalmological Society of Great Britain. Patient was a male of twenty-three years. Right lower eyelid presented an ulcer with indurated base between its central part and the external canthus. Considerable chemosis of conjunctiva ; globe otherwise healthy ; parotid and submaxillary lymphatics hard and large. Secondary symptoms followed in five weeks. Mode of infection unexplained. Mr. Nettleship had seen a parallel case in a girl of three years, where the mode of infection was not understood. Ulcer was painless, confined to the inner surface of the lower lid, followed by an indolent enlargement of the lymphatic glands, and a roseola. The President, Mr. Bowman, suggested that the concurrence of location of the ulcer in the two cases was due to the retention of a foreign body in the cul-de-sac which lies between the sclera and lower lid.—*British Med. Journal*, London, 1882, i, p. 120.

Hard chancre of the lower lid followed by early and severe secondary symptoms.—M. RICHON contributes the following case of this pathological rarity from the military hospital of Belfort. He calls attention to Rollet's statistics, which give two cases among 1,236 chancres in the male ; while of 301 chancres in the female, none were upon the eyelid.

R.'s patient was an infantry soldier, of twenty-two years, of a good constitution, exempt from blepharitis and syphilitic symptoms. He first noticed a little redness at the inner angle of the right eye, on the free border of the lower lid ; this was soon followed by an ulcer, while at the same time the inflammation extended to the surrounding conjunctiva. He was first treated as an ambulant patient ; but when the ulcer became indurated, patient was sent to the hospital. The ulcer is described as situated upon the inferior lachrymal punctum, grayish, superficial, resting on a red, velvety, puffy, and indurated base, which occupied the whole inner part of the lid ; the conjunctiva, of a dark red color,

and chemotic, was the seat of a thick muco-purulent secretion ; the cornea was intact ; there was no pain, nor photophobia, nor lachrymation. The affection, neatly localized at the angle of the lid, whose whole thickness was involved, was evidently neither an inflammatory conjunctivitis nor a scrofulous blepharitis. The relative insignificance of the ulceration to the extent of the engorgement of the base ; the chemosis, limited to the inferior part of the conjunctiva ; the absolute integrity of the cornea ; and, finally, the insensibility of the eye to light, presented a group of signs not common to any of the diseases of the region. The diagnosis was postponed from day to day, and a syphilitic lesion was not at first entertained. After a few days there appeared above and below the angle of the maxilla two small, hard, movable, and indolent ganglia, which led to the first positive indication of the true diagnosis. The patient finally confessed to his infection upon the eye, and the diagnosis was later confirmed by the early manifestation of secondary symptoms. Still later, violent headache at the vertex, tibial pains, with nocturnal exacerbations, and general lassitude with loss of sleep and appetite, were among the symptoms. The ulcer finally cicatrized, but a large cartilaginous induration invaded the whole lid, and produced an ectropion. Iodide of potash in rapidly increasing doses quieted the cephalalgia in four days, and the tibial pains in six days ; while the lassitude persisted several weeks. A papular roseola, confluent on the trunk and discrete on the limbs, was the début of secondary symptoms within three weeks after the appearance of the ganglia at the angle of the jaw. Two days later some buttons of impetigo formed upon the scalp, and a very sensitive circumscribed point of periostitis on the right tibia, a little below and within the anterior tuberosity. Within another week the general malaise disappeared little by little, sleep returned, the palpebral induration was absorbed, the chemosis subsided, and the eye opened easily ; finally, the roseola faded away perceptibly. Within the following week the periostitis became less sensitive, and all the other threatening symptoms yielded rapidly. Still later, after the establishment of a specific anæmia, the hair began to fall out, and symptoms of hemeralopia occurred. The appearance of a stomatitis necessitated an interruption of the mercurial treatment, and a tonic régime was instituted, consisting of wine of quinquina, cod-liver oil, and syrup of the iodide of iron. Under this treatment, the patient proceeded without any other interruption than slight ulcerations of the lips, tonsils, and larynx, which yielded to light cauterizations and insufflations of calomel. Upon dismissal of the patient, the location was marked by a pale redness of the palpebral margin, and by an elongated cicatrix including the obliterated inferior lachrymal punctum.—*Gaz. des hôpitaux*, Paris, 1881, liv, p. 620.

Indurated chancre of the lid.—M. MOTY contributes another case of hard chancre in this region, which occurred in the

military hospital of Saïda in 1872. His case presented several points of analogy to that of the preceding one of M. Richon ; especially as to the induration, ectropion of the lid, and the appearance of the syphilitic fever about one month after that of the initial lesion. In this case, however, the conjunctivitis preceding the development of the necrotic process was more severe, and extended to both eyes. The double conjunctivitis militated against a syphilitic involvement. The anamnesis of the patient gave negative information ; and it was learned in the course of the attack, by dint of direct questions, that during his stay in the hospital patient had repeatedly dipped his eye-compresses in a basin of water in use by venereal patients. In this way patient was guilty of auto-inoculation of syphilis. Worthy of note are : 1. The date of invasion of the syphilitic fever, only twenty-three days after the entrance of the patient to the hospital. 2. The induration of the phlegmon became the location of the initial chancre, so that it was evident that the conjunctivitis and syphilis were contemporaneous.

Another remarkable peculiarity to be noted in this case was the appearance of one of those early gummy tumors described by M. Mauriac in the *Gaz. d. hôpitaux*, 1874 ; the location of the primitive tubercle on the face is not foreign to the anomaly of the evolution of syphilis.—*Gaz. d. hôpitaux*, Paris, 1881, liv, p. 1020.

Syphilis affecting in rare cases the appendages of the eye : with remarks.—MR. STREATFIELD makes the following contributions to the clinical literature of ophthalmic syphilis :

1. Syphilitic inflammation of the lachrymal gland. After prefacing his remarks with a statement of the exceeding rarity of this disease, he introduces his case as one of unmistakable chronic inflammatory enlargement of the lachrymal gland, with as unmistakable a syphilitic origin. Berkeley Hill's exhaustive work on syphilis gives a comprehensive review of all the groups of glands involved in the secondary manifestations of this disease, without alluding to the lachrymal gland. Nettleship, who wrote the chapter on ocular syphilis in this work, had not met with a case ; but, with Bull, of New York, quotes from a German authority one case, where both glands were unequally affected, and the inflammatory symptoms yielded to mercury. Bull's case [referred to in this digest under the theme of Orbital Syphilis] was one of syphilitic periostitis of the orbit, continuing to the fibrous envelope of the gland, thence to its trabeculæ and deep connective tissue. Author's case was one of idiopathic origin, and is thus briefly summarized : A cachectic man, of twenty-five years, came to the Moorfields Eye-Hospital in February, 1881, with a swelling and drooping of the left upper eyelid. The ptosis was mechanical, not paralytic ; at the outer and upper part of this lid over the region of the gland, there was a tough, flat, nodular swelling, thicker superiorly than inferiorly ; not coming down to the lid-border, but extending back under the orbital margin ; not

intimately connected with the skin of the lid or the adjacent subcutaneous parts, which latter were slightly œdematous, red, and tender. Eversion of the lid was painful, but the natural movements of the globe were unaccompanied by pain. The eyeball and orbital walls were not affected in any way. Patient had an attack of catarrhal conjunctivitis about ten months before going to the hospital, from which he recovered; and stated, that six weeks before his appearance there, the red and tender swelling of the left upper lid, now present, began. Two weeks later, a red, brawny swelling appeared at the *right* inner canthus pea-sized, not connected with the lachrymal canals or sac—probably a mucous tubercle. He denied a contraction of chancre, but he had a scaly and papular eruption, of deep coppery color, on the upper forehead, near the capillary line; fauces were congested, but not ulcerated.

Patient was ordered potass. iodid., gr. v, thrice daily, and held to this regimen for six weeks. The œdema of the left upper lid, subsided, the lump over the lachrymal gland was harder and more circumscribed, extending no farther into the orbit than the gland itself; the syphilide was more marked: in addition, pil. hydrarg., gr. ij, twice daily was ordered. In about two months later, the hard swelling of the left upper eyelid had disappeared, as also the red, brawny swelling at the left inner canthus. The rash persisted for a time, and finally disappeared.

It is to be noted that the disease was asymmetrical; but syphilitic iritis, choroiditis, and retinitis are not always binocular in their manifestation; and that the symptoms were not marked, as the patient came because he could not properly open his eye. That it was a primary dacryo-adenitis, may be deduced from its location, shape, outline, and absence of exophthalmos. As to its specificity, patient was then suffering from constitutional syphilis. The adenitis yielded finally to mercury.

2. Syphilitic chancre at the inner canthus. This sore was situated near the lower punctum, just within the lid-margin, and extended around the canthus to the superior punctum, though not evertting either, nor the respective lids. The ocular conjunctiva became gradually œdematous and sodden, and assumed an opaque dead-white appearance. The conjunctival vessels were lost to sight in the œdema. The sore was followed by an adenitis over the parotid, and at the maxillary angle; and later by a sore throat, a roseola over the abdomen, and a few mucous tubercles on the penis and scrotum. Patient was treated with inunctions of unguentum hydrarg. into the thighs, and was discharged in a few weeks, cured in every respect. S. remarks that primary syphilitic sores on the eyelids are seldom seen in England, and that he had seen but two or three previous to the case adduced.—*British Med. Journal*, Sept. 30, 1882, p. 633.

Syphilitic ulceration of the external meatus of the ear.
—Dr. ELY briefly reports “one case of mucous patches in the ex-

ternal auditory canal—a very rare disease.” He also reports “a case of extensive syphilitic ulceration of the external auditory canal and auricle”; the former a male, the latter a female.—*Report of the Ophthalmic Division of Charity Hospital*, Blackwell’s Island, New York, for 1881, Department Press, 1882.

The action of syphilis on the ear.—Dr. F. M. PIERCE, of Manchester, England, presented a paper on this interesting theme to the International Medical Congress in London, 1881, remarking that the effects of congenital and acquired syphilis on the ear are less observed than on the eye, skin, teeth, and other regions. The following are formulated from the official reports:

Syphilitic ear-affections are analogous to corneo-iritis and amaurosis.

The signs and symptoms of syphilitic aural affections must be considered together with the history and collateral signs of syphilis, and the failure of antiscarrhial treatment to relieve apparent scarrhial symptoms.

Are the manifestations due to a periostitis, or to a proliferous inflammation of mucous membranes? If to the former, then osseous affections—as of the mastoid, petrous, and temporal bones,—with inner ear involvement, should preponderate over middle-ear scarrhisms.

Primary sores of the ear are very rare; secondary squamous, pustular, and papular eruptions are common; of these, several cases were adduced.

The evidence of syphilis attacking the middle ear is mainly scarrhial; but there are present anomalous auditory-nerve symptoms, suggestive, in adults, of acquired or congenital syphilis, as a predisposing cause.

Congenital syphilis appears from the eleventh to the eighteenth year; and preponderates in the female four to one.

Deafness comes on gradually but rapidly, in from three weeks to one year; occurs about the age of puberty in females, and rather later in males.

The M. T. is dull, of a pearly opacity, collapsed, light spot large and dull (sometimes double, P.); manubrium of hammer red, flat, and retracted. Meatus dry and polished; nasal passage swollen and crackling.

Deafness is preceded generally by chronic interstitial keratitis (?), whose recovery denotes accession of extreme and intractable deafness. The early decay of the characteristic teeth of congenital syphilis produces frequent earache. Intolerance of sound, like that of light in syphilitic eye-affections, is not a noticeable feature in syphilitic ear-affections.

If most syphilitic aural affections are due to inflammation of the periosteum of the petrous and squamous bones, how are we to explain the rapid loss of auditory-nerve power, which is usually of slow occurrence in such cases.

The following is a summary of aural symptoms, due to syphilis:

1. Deafness extreme, and of early manifestation.
2. Rapid progress, and absence of pain.
3. Early loss of hearing for the tuning-fork over the vertex.
4. Frequent imperviousness of both tubæ Eustach.
5. Constant tinnitus, of a hissing kind.
6. Concurrent labyrinthine symptoms.
7. Improvement of pre- or co-existing ocular affection.
8. More decided naso-pharyngitis than in catarrhal aural disease.
9. Less complete recovery than in simple catarrh.—*Trans. Internat. Med. Congress*, 7th session, London, 1881, iii, p. 399.

RECENT LITERATURE.

- CALHOUN, A. W. Syphilitic ulceration of the eyelid (conjunctiva) in the infant. *Southern Medical Record*, 1882, xii, p. 207.
- GROSSMANN, L. Die syphilitischen Krankheiten des Auges. 2 Iritis. *Pest. med.-chir. Presse*, Budapest, 1882, xviii, pp. 229, 249, 273, 297, 321.
- RAMOS BALAGNER, C. Iritis sifilitica complicada con una queratitis flictenular. *Arch. méd. Valenc.*, Valencia, 1882, ii, p. 220. (*Index Medicus*, 1882, No. 8, p. 377.)

Miscellany.

Death of Hillairet.—Hillairet, one of the physicians of the Hôpital St. Louis, died in Paris, on September 14th, in the sixty-seventh year of his age, with angina pectoris, suddenly, while in the active pursuit of his professional duties. In 1881, he published the first part of a "Traité théorique et pratique des maladies de la peau," comprising 227 pages, devoted to the anatomy and physiology of the skin, and general considerations; he also contributed quite freely to periodical literature on dermatological subjects. He was a member of the French Academy of Medicine and an officer of the Legion of Honor.

Errata.—In Dr. Schumacher's paper, "On Chronic Skin Diseases Treated by the Waters of Aix-La-Chapelle," on page 193, of July issue

Read, Nov.,	+ 5.3° C. (42.° F.)	instead of	+ 5.3° C. (14.° F.)
" Dec.,	— 0.9° C. (30.° F.)	"	— 0.9° C. (3.° F.)
" Jan.,	+ 1.9° C. (35.° F.)	"	+ 1.9° C. (5.° F.)
" Feb.,	+ 4.1° C. (40.° F.)	"	+ 4.1° C. (11.° F.)
" March,	+ 5.6° C. (43.° F.)	"	+ 5.6° C. (10.° F.)
" April,	+ 9.6° C. (49.° F.)	"	+ 9.6° C. (26.° F.)

Editorial.

CESSATION OF PUBLICATION.

WITH this issue and the completion of Volume Eighth, the ARCHIVES OF DERMATOLOGY will cease its existence. For several years the pressure of other work has rendered it very difficult for the Editor to devote sufficient time and energy to its publication, and the recent appearance of a monthly journal of cutaneous and venereal diseases has seemed to offer a fit occasion for its discontinuance: the interests of dermatology will be well served by the new monthly, while the Index Medicus furnishes the references to dermatological literature, which occupied much space in the pages of the ARCHIVES.

It is not too much to claim that the ARCHIVES OF DERMATOLOGY has assisted in developing in this country an interest in and sound knowledge of this branch, which has been far too greatly neglected by the profession. The aim has been to make the journal a faithful exponent of this department in this and other countries, and the matter contributed to its pages shows an activity of thought and observation scarcely exceeded by that in any other branch of medicine.

More than one hundred and sixty original articles have appeared in its pages, besides sixty-four minor contributions in the form of clinical reports, by some ninety different writers, most of whose names are well known to science.

The abstracts from journals have been prepared by thirty-eight different collaborators, many of whom are well known by their original contributions to the subject. For this vast amount of arduous labor we extend our most heartfelt thanks, and to it attribute largely the high character of the literary and scientific worth which has always been so kindly accorded to the ARCHIVES OF DERMATOLOGY by the medical press.

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